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June 20, 2024

Ms. Elizabeth Matney
Medicaid Director
Iowa Medicaid
Department of Health and Human Services
1305 East Walnut Street
Des Moines, IA 50319-0114

PROPRIETARY AND CONFIDENTIAL

Subject: **SFY25 IA Health Link Managed Care Rate Development**

Dear Ms. Matney:

Thank you for the opportunity to assist the Department of Health and Human Services (HHS) and Iowa Medicaid with the development of the SFY25 IA Health Link capitation rates. The following report summarizes the methodology for the development of the capitation rates, effective July 1, 2024 – June 30, 2025 (SFY25). We have also provided our actuarial certification for these capitation rates, compliant with CMS guidelines and requirements. Please send me an email at barry.jordan@optumas.com or call me at 480.588.2492, or email Stephanie at stephanie.taylor@optumas.com if you have any questions.

Sincerely,

Barry Jordan, FSA, MAAA
Director/Consulting Actuary, CBIZ Optumas

Stephanie Taylor, ASA, MAAA
Sr. Manager/Consulting Actuary, CBIZ Optumas

CC: Joanne Bush, Iowa Medicaid
Jared Nason, CBIZ Optumas
Clifford Morrison, CBIZ Optumas

CBIZ Optumas, LLC
7400 East McDonald Dr., Suite 101
Scottsdale, AZ 85250
480-588-2499

Iowa Medicaid

IA Health Link Actuarial Certification

July 1, 2024 – June 30, 2025 Capitation Rates

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Executive Summary

Background

This report provides documentation and actuarial certification for the IA Health Link capitation rate development for rates effective July 1, 2024 – June 30, 2025 (SFY25).

The Iowa Department of Health and Human Services (HHS) implemented the IA Health Link program on April 1, 2016 as part of the Medicaid Modernization initiative. The majority of Iowa Medicaid members are enrolled in the IA Health Link program and receive physical health, behavioral health, pharmacy prescriptions, and long-term supports and services through the contracted managed care organizations (MCOs). A small portion of Medicaid members continue to be served through Medicaid fee-for-service (FFS). The Medicaid Modernization initiative aims to improve quality and access to care, promote accountability for patient outcomes, and create a more predictable and sustainable budget.

This document provides an explanation of the methodologies used in the development of the capitation rates for the IA Health Link program effective July 1, 2024 through June 30, 2025 (SFY25). Iowa Medicaid first contracted with CBIZ Optumas (Optumas) to develop actuarially sound capitation rates for the IA Health Link program beginning with the July 1, 2018 through June 30, 2019 (SFY19) rate development.

When the IA Health Link program began on April 1, 2016, three MCOs were contracted with Iowa Medicaid. Since then, the program has had two or three MCOs operating the program within each rating period. Within the SFY25 contract period the following health plans are contracted with Iowa Medicaid with the date they entered the Iowa Medicaid market noted:

- Wellpoint Iowa, Inc. (formerly known as Amerigroup Iowa, Inc. prior to January 1, 2024)
    - Operating since the program's inception on April 1, 2016.
- Iowa Total Care (ITC)
    - Entered the market on July 1, 2019.
- Molina Healthcare of Iowa
    - Entered the market on July 1, 2023.

As the consulting actuaries to HHS and Iowa Medicaid (State), Optumas worked with the State to create an appropriate rate setting methodology for the SFY25 IA Health Link capitation rates. Optumas ensured the methodology used to develop the SFY25 rates complies with the Centers for Medicare & Medicaid Services (CMS) guidance for the development of actuarially sound rates, 42 Code of Federal Regulations (CFR) §438.4, as well as 438.5, 438.6, and 438.7. Optumas worked with the State to identify the necessary rate development components for the SFY25 rating period, accounting for the covered services and populations as described in the IA Health Link contracts. The final rates were developed according to actuarially sound principles and reasonably reflect the experience projected for the SFY25 IA Health Link program.

This document is structured consistent with the CMS 2024-2025 Medicaid Managed Care Rate Development Guide. Any sections that are not applicable are noted as such but have been included for completeness.

Summary of Capitation Rates

In developing the SFY25 capitation rates, Optumas adhered to guidance provided by CMS in accordance with 42 CFR §438.4, the CMS standards for developing actuarially sound capitation rates for Medicaid managed care programs. CMS defines actuarially sound rates as meeting the following criteria:

I. They have been developed in accordance with generally accepted actuarial principles and practices,
II. They are appropriate for the populations to be covered and the services to be furnished under the contract, and
III. They have been certified by an actuary who meets the qualification standards established by the American Academy of Actuaries and follows practice standards established by the Actuarial Standards Board.

Optumas specifically considered the following Actuarial Standards of Practice (ASOPs) when developing the IA Health Link capitation rates:

- ASOP 1 – Introductory Actuarial Standard of Practice
- ASOP 5 – Incurred Health and Disability Claims
- ASOP 12 – Risk Classification (for All Practice Areas)
- ASOP 23 – Data Quality
- ASOP 25 – Credibility Procedures
- ASOP 41 – Actuarial Communications
- ASOP 45 – The Use of Health Status Based Risk Adjustment Methodologies
- ASOP 49 – Medicaid Managed Care Capitation Rate Development and Certification
- ASOP 56 – Modeling

Optumas worked in conjunction with Iowa Medicaid to develop an appropriate rate setting methodology which incorporated the necessary adjustments to ensure that the rates for the contract period were reasonable, appropriate, and attainable. The body of this document outlines the CMS 2024-2025 Medicaid Managed Care Rate Development Guide with compliance to each section discussed in detail.

The certified capitation rates for the IA Health Link managed care program gross of withholds and the additional graduate medical education (GME) and ground emergency medical transportation (GEMT) payments, effective July 1, 2024 - June 30, 2025, can be found in Appendix I.A. Note that estimates associated with directed payments that are operationalized as separate payment terms are not included within Appendix I.A but are shown later in Appendix I.C, as they are not explicitly built into the capitation rates.

Fiscal Impact Estimate

The estimated aggregate fiscal impact of the SFY25 IA Health Link rate changes, gross withhold and net additional payments, is an annual increase of $270.8M based on SFY23 enrollment, which is the base data period used for rate development. The annual fiscal impact is shown in Appendix II.A and is based

on a comparison of the SFY25 certified capitation rates and the SFY24 Mid-Year Addendum rates, certified on February 29, 2024.

Rate Development Summary

A brief description of each component in the rate development process is shown in Appendix II.B. Each step of the SFY25 rate development will be discussed in further detail throughout the remainder of the document.

Section I. Medicaid Managed Care Rates

1. General Information

A. Rate Development Standards

i. Rate Range Standards

Optumas understands that unless otherwise stated, all standards and documentation expectations outlined in the CMS rate development guide for capitation rates also apply for the development of the upper and lower bounds of rate ranges, in accordance with 42 CFR §438.4(c). Optumas is certifying capitation rates and not capitation rate ranges. As such, any sections pertaining only to capitation rate ranges are not applicable but have been included for completeness.

ii. Contract Period

The rates contained in this certification are effective for the one-year period from July 1, 2024 through June 30, 2025 (SFY25).

iii. Required Components

Letter from Certifying Actuary

The rates contained in this document have been certified by Barry Jordan, Member of the American Academy of Actuaries (MAAA), and a Fellow of the Society of Actuaries (FSA) and Stephanie Taylor, Member of the American Academy of Actuaries (MAAA), and an Associate of the Society of Actuaries (ASA). Mr. Jordan and Ms. Taylor meet the requirements for an actuary in 42 CFR §438.2 and have certified that the final capitation rates meet the standards in 42 CFR §§ 438.3(c), 438.3(e), 438.4, 438.5, 438.6, and 438.7. The certification letter is included at the end of this document.

Final Certified Capitation Rates

The final and certified capitation rates for all rate cells are provided in Appendix I.A in accordance with 42 CFR §438.4(b)(4) and 42 CFR §438.3(c)(1)(i).

Description of Program

The Iowa Department of Health and Human Services (State) developed the IA Health Link program by contracting with three managed care organizations (MCOs) to begin service on April 1, 2016 as part of the Medicaid Modernization initiative. The majority of existing Medicaid members were enrolled on April 1, 2016 and most newly eligible Medicaid members continue to be enrolled in IA Health Link in subsequent years. A small portion of Medicaid members are served through Medicaid fee-for-service (FFS). The objectives of the Medicaid Modernization initiative are to improve quality and access to care, promote accountability for patient outcomes, and create a more predictable and sustainable budget.

When the IA Health Link program began on April 1, 2016, three MCOs were contracted with Iowa Medicaid. Since then, the program has had two or three MCOs operating the program within each rating

period. Within the SFY25 contract period the following health plans are contracted with Iowa Medicaid with the date they entered the Iowa Medicaid market noted:

- Wellpoint Iowa, Inc. (formerly known as Amerigroup Iowa, Inc. prior to January 1, 2024)
  - Operating since the program's inception on April 1, 2016.
- Iowa Total Care (ITC)
  - Entered the market on July 1, 2019.
- Molina Healthcare of Iowa
  - Entered the market on July 1, 2023.

MCOs participating in the IA Health Link program are required to provide benefits that include physical health, long-term supports and services, behavioral health, and pharmacy prescriptions. As outlined in the MCO contracts, Iowa Medicaid has carved out high-cost drugs with a per individual dose or treatment cost of $1.5M or greater from the services covered under the capitation rates. The MCOs will provide coverage of these drugs to eligible beneficiaries consistent with other pharmaceuticals and treatments; however, the State will reimburse the MCOs via invoices billed to Iowa Medicaid. Within the SFY23 contract period, Zolgensma and Mepsevii were the only applicable drugs reimbursed outside of the capitation rates. Experience for Mepsevii was not observed within the SFY23 base data experience, but all Zolgensma encounters have been carved out of the base data used for rate development.

Dental services and the Program of All-Inclusive Care for the Elderly are covered under separate managed care programs for the eligible populations. The base data was summarized into rating Categories of Service (COS) consistent with the SFY24 rate development, with the addition of Indian Health Services, shown in *Table 1* below:

Table 1. Rating Categories of Service

Categories of Service (COS)	
Behavioral Health – Inpatient	Laboratory (Lab)/Radiology (Rad)
Behavioral Health – Outpatient	Nursing Home and Hospice
Behavioral Health – Professional	Other Care
Day Services	Other Home- and Community-Based Services (HCBS)
Durable Medical Equipment (DME)/Prosthetics	Outpatient – Emergency Room
Family Planning	Outpatient – Non-Emergency Room
Federally Qualified Health Center (FQHC)/Rural Health Center (RHC)	Outpatient – Professional
Home Health	Pharmacy
Intermediate Care Facility for the Intellectually Disabled (ICF/ID)	Professional Office
Indian Health Services	Transportation
Inpatient	Waiver
Inpatient - Professional	

MCOs participating in the IA Health Link program are required to provide benefits for all eligible populations. Populations have been grouped by similar risk patterns and specific rates have been set for each rate cell in accordance with 42 CFR §438.4(b)(4) and 438.7(c). The individual rate cells used for the SFY25 rate development are consistent with historical contract periods. For summary purposes, these

rate cells have been grouped into the following high-level Categories of Aid (COA) shown in *Table 2* below:

Table 2. IA Health Link Rate Cells and COA

Rate Cell	COA
Children 0-59 days old, Male and Female (M&F)	Children
Children 60-364 days M&F	Children
Children 1-4 M&F	Children
Children 5-14 M&F	Children
Children 15-20 F	Children
Children 15-20 M	Children
Children's Health Insurance Program (CHIP) - Hawki	Children
Non-Expansion Adults 21-34 F	Temporary Assistance for Needy Families (TANF) Adult
Non-Expansion Adults 21-34 M	TANF Adult
Non-Expansion Adults 35-49 F	TANF Adult
Non-Expansion Adults 35-49 M	TANF Adult
Non-Expansion Adults 50+ M&F	TANF Adult
Pregnant Women	Pregnant Women
Wellness Plan (WP) 19-24 F (Medically Exempt)	Wellness Plan
WP 19-24 M (Medically Exempt)	Wellness Plan
WP 25-34 F (Medically Exempt)	Wellness Plan
WP 25-34 M (Medically Exempt)	Wellness Plan
WP 35-49 F (Medically Exempt)	Wellness Plan
WP 35-49 M (Medically Exempt)	Wellness Plan
WP 50+ M&F (Medically Exempt)	Wellness Plan
WP 19-24 F (Non-Medically Exempt)	Wellness Plan
WP 19-24 M (Non-Medically Exempt)	Wellness Plan
WP 25-34 F (Non-Medically Exempt)	Wellness Plan
WP 25-34 M (Non-Medically Exempt)	Wellness Plan
WP 35-49 F (Non-Medically Exempt)	Wellness Plan
WP 35-49 M (Non-Medically Exempt)	Wellness Plan
WP 50+ M&F (Non-Medically Exempt)	Wellness Plan
Aged, Blind, and Disabled (ABD) Non-Dual <21 M&F	Disabled
ABD Non-Dual 21+ M&F	Disabled
Residential Care Facility	Disabled
Breast and Cervical Cancer	Disabled
Dual Eligible 0-64 M&F	Dual
Dual Eligible 65+ M&F	Dual
Custodial Care Nursing Facility <65	Institutional
Custodial Care Nursing Facility 65+	Institutional
Elderly HCBS Waiver	Waiver
Non-Dual Skilled Nursing Facility	Institutional
Dual HCBS Waivers: Physically Disabled (PD); Health and Disability (H&D)	Waiver

Rate Cell	COA
Non-Dual HCBS Waivers: PD; H&D; Acquired Immunodeficiency Syndrome (AIDS)	Waiver
Brain Injury HCBS Waiver	Waiver
Intermediate Care Facility for persons with an Intellectual Disabled (ICF/ID)	Institutional
State Resource Center (SRC)	Institutional
Intellectual Disability HCBS Waiver	Waiver
Psychiatric Mental Institute for Children (PMIC)	Institutional
Children's Mental Health HCBS Waiver	Waiver
CHIP - Children 0-59 days M&F	Children
CHIP - Children 60-364 days M&F	Children
CHIP - Children 1-4 M&F	Children
CHIP - Children 5-14 M&F	Children
CHIP - Children 15-20 F	Children
CHIP - Children 15-20 M	Children
TANF Maternity Case Rate	Maternity Case Rate
Pregnant Women Maternity Case Rate	Maternity Case Rate

The certification letter includes documentation for the following special contract provisions related to payment underlying the capitation rates:

- Withhold arrangement,
- Minimum medical loss ratio requirement,
- Program-wide risk corridor arrangement, and
- State directed payments and alternative minimum fee schedule payments per 42 CFR §438.6(c).

The rates certified within this document are the original capitation rates for the SFY25 contract period. If the State and Optumas determine that a retroactive adjustment to the capitation rates is necessary, these retroactive adjustments will be certified by an actuary in a revised certification and submitted as a contract amendment in accordance with 42 CFR §438.7(c)(2). The revised rate certification will include a description of the rationale for the adjustment, the data, assumptions, and methodologies used to develop the magnitude of the adjustment, whether the state adjusted rates in the rating period by a *de minimis* amount in accordance with 42 CFR §438.7(c)(3) prior to the submission of the rate amendment, and will address and account for all differences from the most recently certified rates.

iv. Differences Among Capitation Rate Assumptions

Any differences in the assumptions, methodologies, and factors used to develop the SFY25 IA Health Link capitation rates for covered populations are based on valid rate development standards that represent actual cost differences in providing covered services to the covered populations. Any differences in the assumptions, methodologies, and factors used to develop the SFY25 IA Health Link capitation rates do not vary with the rate of Federal financial participation (FFP) associated with the covered populations in a manner that increases Federal costs.

v. Rate Cell Cross-Subsidization

There is no rate cell cross-subsidization within the SFY25 IA Health Link capitation rates.

vi. Program Change Effective Dates

The effective dates of changes to the IA Health Link Medicaid managed care program are consistent with the assumptions used to develop the capitation rates. The assumptions and adjustments are described in greater detail in Section I.2 in this document.

vii. Medical Loss Ratio (MLR)

The IA Health Link program capitation rates were developed using generally accepted actuarial practices and principles. The rates were developed in such a way that they provide reasonable, appropriate, and attainable non-benefit costs and that each MCO would reasonably achieve an MLR of at least 85% for the contract period. The State requires a minimum MLR of 88% for the MCOs operating within the IA Health Link program for SFY25. Further details on this arrangement are described within the Risk-Sharing Mechanisms section of this document.

viii. Rate Range Certification

This document certifies the specific SFY25 IA Health Link rates for each rate cell and does not certify a range of capitation rates for each rate cell.

ix. Rate Range Documentation

This document certifies the specific SFY25 IA Health Link rates for each rate cell and does not certify a range of capitation rates for each rate cell.

x. Generally Accepted Actuarial Practices

Reasonable, Appropriate, and Attainable Costs

All adjustments to the capitation rates, or to any portion of the capitation rates, reflect reasonable, appropriate, and attainable costs in the actuary's judgment and are included in the rate certification.

Adjustments Outside the Rate Setting Process

No adjustments are made outside of the rate setting process described in the rate certification. Adjustments to the rates that are performed outside of the rate setting process described in the rate certification are not considered actuarially sound under 42 CFR §438.4.

Final Contracted Rates

Consistent with 42 CFR §438.7(c), the final contracted rates in each rate cell match the capitation rates in the rate certification.

xi. Rate Certification Periods

The rates in this document were developed for the SFY25 contract period and are certified for the SFY25 period, effective from July 1, 2024, through June 30, 2025.

xii. COVID-19 Public Health Emergency (PHE)

Optumas developed an acuity adjustment to model the impact of the changing per-member per-month (PMPM) costs associated with the disenrollments that have occurred due to the end of the PHE continuous eligibility requirement (disenrollment freeze). Additional details related to this adjustment are provided in Section I.7 of this document. Other COVID-19 PHE-related adjustments are described in Section I.2.

For the SFY25 contract period there will continue to be a two-sided risk mitigation strategy in response to the COVID-19 PHE unwind.

Optumas has included narrative support describing the evaluation conducted, and the rationale for any applicable assumptions included or not included in rate development related to the COVID-19 PHE unwind within the applicable sections of this rate certification.

xiii. Amendments

Federal Financial Participation (FFP)

The State of Iowa intends to claim FFP for the IA Health Link capitation rates and will comply with the time limit for filing claims for FFP specified in section 1132 of the Social Security Act and implementing regulations at 45 CFR Part 95.

Changes to Rates

Any changes to the rates will result in the submission of a new rate certification, except for changes permitted as specified in 42 CFR §438.4(c) or 42 CFR §438.7(c)(3).

Contract Amendments

If contract amendments revise the covered populations, services furnished under the contract, or other changes that could reasonably change the rate development and rates, supporting documentation will be provided indicating the rationale as to why the rates continue to be actuarially sound in accordance with 42 CFR §438.4.

Limited Payment Changes

Supporting documentation rather than a new or revised certification will be provided to CMS if the actuarially sound capitation rates per rate cell outlined in this certification increase or decrease, as required in 42 CFR §§ 438.7(c) and 438.4(b)(4), up to 1.5% during the rating period, in accordance with 42 CFR §438.7(c)(3).

Other Changes

A contract amendment will be submitted any time a rate changes for any reason other than application of an approved payment term included in the initial managed care contract.

Changes in Federal Statutes or Regulatory Authority

Optumas and Iowa Medicaid will submit a rate amendment if any IA Health Link program features are invalidated by courts of law, or by changes in federal statutes, regulations, or approvals. The rate amendment will adjust the capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law, taking into account the effective date of the loss of program authority.

B. Appropriate Documentation

i. Certification of Capitation Rates or Rate Ranges

This document certifies the specific SFY25 IA Health Link rates for each rate cell and does not certify a range of capitation rates for each rate cell.

ii. Documentation of Data, Assumptions, and Methodology

Data used, secondary data sources, justification for assumptions, and methods for analyzing data and developing adjustments are described in the relevant sections of this certification letter.

iii. Medical Loss Ratio (MLR)

The IA Health Link program capitation rates were developed using generally accepted actuarial practices and principles. The rates were developed in such a way that they provide reasonable, appropriate, and attainable non-benefit costs and that each MCO would reasonably achieve an MLR of at least 85% for the contract period. The State requires a minimum MLR of 88% for the MCOs operating within the IA Health Link program for SFY25. Further details on this arrangement are described within the Risk-Sharing Mechanisms section of this document.

iv. Rating Assumption Variations

This document provides rate certification for the IA Health Link program, and the actuaries certify to specific rates for each rate cell, not rate ranges, in accordance with 42 CFR §§ 438.4(b)(4) and 438.7(c). The certification discloses and supports the specific assumptions that underlie the certified rates for each rate cell, including the magnitude and narrative support for each specific assumption or adjustment. To the extent assumptions or adjustments underlying the capitation rates vary between managed care plans, the certification describes the basis for this variation.

v. Rate Range Requirements

This document certifies the specific SFY25 IA Health Link rates for each rate cell and does not certify a range of capitation rates for each rate cell.

vi. Index

This rate certification follows the structure of the CMS 2024-2025 Medicaid Managed Care Rate Development Guide. The table of contents at the beginning of this document serves as an index that documents the page number or the section number for the items described within the guidance. Inapplicable sections of the guidance are included for completeness and marked as "Not Applicable."

vii. FFP Assurance

Optumas confirms that any proposed differences in the assumptions, methodologies, or factors used to develop capitation rates for covered populations comply with 42 CFR §438.4(b)(1) and are based on valid rate development standards that represent actual cost differences in providing covered services to the covered populations. These differences do not vary with the rate of FFP associated with the populations in a manner that increases federal costs.

viii. FMAP

There are services, populations, or programs for which the state receives a different federal medical assistance percentage (FMAP) than the regular state FMAP. Appendix I.A contains final capitation rates by rate cell.

ix. Rate Change Comparison

A comparison of the statewide SFY25 capitation rates to the IA Health Link SFY24 Mid-Year Addendum rates is shown in Appendix II.A.

In aggregate across all rate cells, there is an approximate 3.8% rate increase between the SFY24 Mid-Year Addendum rates and SFY25 capitation rates. The SFY24 rate development relied on SFY22 base data experience while SFY25 relied on SFY23 base data experience. As a result, some rate cells have rate changes that are primarily driven by the changes in underlying base data.

The following rate cells have statewide rate changes greater than +/- 10% between the IA Health Link SFY24 Mid-Year Addendum rates and the SFY25 capitation rates:

- Children 1-4 M&F and CHIP – Children 1-4 M&F
- Children 15-20 F and CHIP – Children 15-20 F
- Pregnant Women
- WP 19-24 M (Medically Exempt)
- WP 19-24 M (Non-Medically Exempt)
- Residential Care Facility
- Dual Eligible 0-64 M&F

The driver of the large rate changes for most of these rate cells is a combination of the revised base data, which reflects a shift from SFY22 to SFY23 and larger increases related to the COVID-19 PHE unwind acuity adjustment compared to the SFY24 rates due to disenrollments being fully complete in SFY25 as opposed to ongoing disenrollments throughout the SFY24 contract period which dampens the impact. The large rate change for Pregnant Women is driven primarily by the postpartum coverage adjustment which removes postpartum experience in excess of two months, since only two months of postpartum coverage will be covered following the end of the PHE.

All components of the rate development and material changes to the capitation rates between the IA Health Link SFY24 and SFY25 rates are described in further detail within the remainder of the document. Each component of the rate development process is shown within Appendix I.B.

x. Known Amendments

The following rating adjustments are expected to be made within a future rate amendment for the SFY25 contract period:

- Adjustments for legislatively approved policy changes that at the time of rate development were not yet signed by the Governor's office but are expected to have an effective date within SFY25.
- SFY25 provider fee updates that may include ICF/ID, SRC, Nursing Facility, and Critical Access Hospitals. The rates reflect the current SFY24 fee schedules for these services.
- Dispensing fee changes based on the results of the dispensing fee survey.
- Certified Community Behavioral Health Clinic (CCBHC) implementation.
- Impact associated with 90-day scripts policy change. This is anticipated to be a smaller adjustment than currently built into the rates due to fewer dispensing fees being paid for applicable drugs.
- Adjustment for Wegovy coverage (currently not included in the Preferred Drug List) as policy regarding coverage requirements is still pending from HHS.
- Modification to the HCBS care coordination ratio and reporting requirements and implications on non-medical load.
- A legislatively mandated premium tax change, reducing the tax from 0.975% to 0.95%, is expected to occur effective January 1, 2025.

An amendment is expected to be provided to CMS in August or September of 2024 documenting the impact of these rating adjustments.

The only other known amendments that will be provided to CMS in the future associated with the SFY25 capitation rates are the reconciliations associated with the separate payment term directed payments which are reimbursed outside of the capitation rates. Consistent with CMS requirements, Optumas has included initial PMPM estimates by rate cell associated with these separate payment term arrangements in Appendix I.C. Once the contract period is over, Iowa Medicaid and Optumas will perform a reconciliation and revise the PMPMs based on actual directed payment utilization rendered within the SFY25 contract period.

xi. COVID-19 Public Health Emergency Documentation

State Specific, National, or Regional Data and Information

Optumas used IA Health Link managed care encounter data in determining how to address the COVID-19 PHE unwind within the SFY25 rate development. In particular, Optumas reviewed emerging IA Health Link encounters and enrollment data through March 2024. Additional details on the specific data and assumptions used for each rating adjustment are included within the program change descriptions later in this document.

Description of Direct and Indirect Impacts

The SFY25 IA Health Link capitation rates directly account for the impacts of the COVID-19 PHE unwind through various rating adjustments described later in this document. The base data used for rate development is SFY23 data which includes impacts of COVID-19 after vaccines were widely available. The following rating adjustments were made to reflect expected changes in service utilization and member behavior between the SFY23 base data and SFY25 contract period as a result of policy changes associated with the ending of the PHE:

- COVID-19 Testing
- COVID-19 Meals
- Pharmacy 90-Day Supply Removal

An explicit acuity adjustment was made as a result of the COVID-19 PHE unwind and the significant member disenrollments that occurred at the end of SFY23 and throughout SFY24. More information on this adjustment is provided in Section I.7 of this document.

Non-Risk Basis Costs

No adjustment for the administration of COVID-19 vaccines has been made within the SFY25 rate development. Iowa Medicaid will continue to reimburse the MCOs for the cost of administering the vaccine outside of the capitation rates as a non-risk payment via direct invoicing in a manner similar to high-costs drugs in excess of $1.5M, consistent with the SFY24 rates. All COVID-19 vaccine administration invoices must be submitted no later than 12 months from the date of service and must be backed by claim level detail sufficient to support the invoice. The COVID-19 vaccines were identified and excluded from the underlying SFY23 encounter data used for base development.

Risk Mitigation Strategies

Consistent with the SFY24 contract period, a two-sided risk corridor and minimum MLR requirement remain in place for the IA Health Link program for the SFY25 contract period as a result of the uncertainties associated with the ending of the COVID-19 pandemic. The structure of the risk corridor and minimum MLR are the same as the SFY24 contract period.

2. Data

A. Rate Development Standards

i. Base Data

Encounter Data, FFS Data, and Audited Financial Reports

As part of the SFY25 rate setting process, Optumas received detailed IA Health Link Medicaid Management Information System (MMIS) encounter data, FFS data, and State eligibility and Health Link capitation payments from the program's inception (April 1, 2016) through April 30, 2024, with encounter submissions through April 2024. This data reflects actual experience for the Medicaid populations served by the IA Health Link MCOs. Optumas received member-level capitation files that were used to match up to the detailed encounters to ensure all claims used for rate development were for IA Health Link enrolled members.

Optumas summarized the data for comparison with financial templates that were submitted by each of the MCOs who have operated within the IA Health Link program to help validate the MMIS encounter data. The detailed capitations and encounters for the emerging IA Health Link experience were also benchmarked to the base data used within the SFY24 rate development.

Appropriate Base Data

Optumas selected SFY23 (July 1, 2022 – June 30, 2023) encounter data as the base data for the SFY25 rate development. The SFY23 encounters represent the most recent complete year of IA Health Link program experience available at the time of rate development.

Medicaid Population

The SFY23 base data used for rate setting represents detailed encounter data and enrollment for the Medicaid population in Iowa, as it consists of actual experience for the IA Health Link program.

Exceptions

The base data used for this rate setting falls within the most recent and complete three years prior to the rating period so no request for an exception is necessary.

B. Appropriate Documentation

i. Base Data

Data Requested by Actuary

Optumas requested all encounter data for the IA Health Link Program (April 2016 – April 2024), FFS claims, and all corresponding eligibility and capitation information from Iowa Medicaid. Additionally,

Optumas requested summarized financial data from each MCO reported in financial templates through the end of CY23.

Data Provided

Iowa Medicaid and the MCOs provided all of the information requested by Optumas, as noted above.

Data Not Provided

All data requested was provided by Iowa Medicaid.

ii. Rate Development Data

Data Description

The base data used for the SFY25 rate setting consists of SFY23 encounters and capitation data from the IA Health Link program. Additional IA Health Link encounters outside of the SFY23 time period, as well as MCO financial summaries, and MCO detailed enrollment data were used to inform assumptions or adjustments to the base data. The data used to inform adjustments and program changes within the rate setting process is described for each adjustment throughout the document and a brief summary has been included in *Table 3* below:

Table 3. Data Source Summary

Data Type	Data Source	Level of Detail	Start Date	End Date
MMIS Encounters	Iowa Medicaid	Detailed	04/01/2016	4/30/2024
Capitation Payments	Iowa Medicaid	Detailed	04/01/2016	4/30/2024
FFS Claims	Iowa Medicaid	Detailed	01/01/2015	4/30/2024
Eligibility	Iowa Medicaid	Detailed	01/01/2015	4/30/2024
Financial Template (Encounters, other medical-related costs, admin, and enrollment)	All MCOs	Summarized	04/01/2016	12/31/2023

Optumas uses the paid amount submitted within the MMIS encounter data as the basis of rate development. The paid amount within the MMIS encounter data is net of third-party liability coverage (TPL), copays, and patient liability amounts and reflects the amount that the MCOs pay to providers for services rendered within the SFY23 base data period. HHS and Iowa Medicaid do not dictate the payment structure for any of the MCO value-based purchasing (VBP) arrangements that are part of the general MCO contracts. Since the IA Health Link MMIS encounter experience is used as the basis of rate development the base data inherently reflects all provider reimbursement arrangements that the MCOs have in place. Thus, there are no additional adjustments necessary within the rate development process to account for the VBP arrangements that the MCOs are implementing in order to meet any contract requirements.

The base data reflects non-subcapitated claim payments from the MCOs to providers for services incurred during the SFY23 time period. The GEMT state directed payment program began on July 1, 2019. The enhanced reimbursement for these services is billed under procedure code A0999, which has

been excluded from the base data to avoid duplication. An estimate for the impact of this directed payment is reflected in the rates at the end of the rate development and is described in Section I.4.D of this document.

Per the MCO contracts, certain high-cost drugs costing $1.5M or more per dose or treatment are excluded from the capitation rates. Only one claim for Zolgensma was incurred during the SFY23 contract period and the utilization and cost for this claim was excluded from the base data compilation. Additionally, claims for value-added services that are not covered by the IA Health Link contract are reviewed and removed to the extent they are inherent in the MMIS encounters. Iowa Medicaid and the MCOs provided Optumas with the necessary logic to identify these services and exclude them from the encounters underlying the SFY23 base data that was summarized and compared to the reported MCO financials.

Iowa Medicaid will be reimbursing the MCOs for the cost of administering the COVID-19 vaccine outside of the capitation rates as a non-risk payment via direct invoicing in a manner similar to Zolgensma and other high-cost drugs noted previously in this document. This process is consistent with the SFY24 rates. No adjustment was necessary to the underlying SFY23 base data since the COVID-19 vaccines were not included in the underlying encounter claims data used for base development.

The IA Health Link MCOs have subcapitated arrangements for a small suite of services that varies by MCO. The underlying claims associated with MCO subcapitated services are inherent within the MMIS encounter data received from Iowa Medicaid. Additionally, the MCOs report the subcapitated services within the financial templates for Optumas to monitor and validate against the MMIS encounter data. Optumas excluded the MMIS subcapitated encounters from the initial base data used for rate development and reincorporated the MMIS subcapitated encounters after the application of IBNR. Further details on the subcapitated adjustment within the base data development is described below in Section I.2.B.iii.

Data Availability and Quality

Optumas validated the detailed MMIS encounter data through the use and review of control totals, financial templates, and monthly volume comparisons. Optumas has no concerns with the completeness or the accuracy of the IA Health Link MMIS encounter data used as the basis of rate development. As discussed in Section I.2.b.iii below, the MMIS encounters are consistent with the reported financials provided by the IA Health Link MCOs and very minimal reporting adjustments are necessary to align the MMIS encounter data with the MCO financial reports.

To ensure compliance with ASOP 23 – Data Quality, Optumas conducted the following data validation analyses as part of the initial steps of the rate development process:

1. **Referential Integrity Checks** – Optumas ensured that all encounters included in base data were incurred by a member with a valid Medicaid eligibility span that coincided with the incurred date associated with the specific encounter.

2. **Volume Checks** – Optumas checked both volume of encounters and service expenditures by looking at utilization, unit cost, and PMPM expenditures totals longitudinally by COA and COS. This ensured

that any gaps or spikes in the data were identified and addressed before creating the base data. No additional adjustments to the SFY23 base data were required.

3. **Benchmark Comparison** – Optumas compared summarized data to other base data summaries used in reference programs in other states for benchmarking purposes. Additionally, Optumas compared the MMIS encounter data to the reported financials from the MCOs to ensure consistency of the data across sources and that the SFY23 base data used for rate development was complete.

Optumas relied upon the encounter, FFS, and capitation data provided by HHS and the contracted MCOs. Optumas determined that the data used was suitable for the purpose of developing actuarially sound rates for the SFY25 contract period since there were no concerns over the availability or quality of the data received from the State.

Appropriate Data

Optumas chose to limit the base data to SFY23 encounter data since the SFY23 time period represents the most recent complete year of data available for the IA Health Link program at the time of rate development.

Reliance on a Databook

Optumas did not rely on an external databook in developing the SFY25 IA Health Link capitation rates and instead relied on detailed encounter and capitation data for the Health Link program for the SFY23 time period. Data sources used in rate development are described in the preceding sections.

iii. Adjustments

Data Credibility

Optumas worked with Iowa Medicaid and the MCOs to ensure the detailed encounter data and MCO financial templates were interpreted correctly and applied consistently within rate development. Through the financial comparison analyses Optumas determined that a combined Incurred But Not Reported (IBNR) and Reporting adjustment of 0.2% was necessary to fully capture the MCO medical encounter expenditures for the SFY23 base data time period.

Consistent with historical IA Health Link rate development cycles since the program's inception, certain CHIP rate cell populations were deemed to have insufficient enrollment volume to develop stand-alone rates. As a result, all non-Hawki CHIP enrollment, costs, and utilization were included with the more substantial corresponding Medicaid children rate cells to enhance credibility. The combined rate cells are shown within *Table 4* below.

Table 4. CHIP Children Rate Cells

Original Rate Cell	Combined Rate Cell
CHIP – Children 0-59 days M&F	Children 0-59 days M&F
CHIP – Children 60-364 days M&F	Children 60-364 days M&F
CHIP – Children 1-4 M&F	Children 1-4 M&F

Original Rate Cell	Combined Rate Cell
CHIP – Children 5-14 M&F	Children 5-14 M&F
CHIP – Children 15-20 F	Children 15-20 F
CHIP – Children 15-20 M	Children 15-20 M

There are no differences in the underlying Medicaid benefit packages between Medicaid Children and CHIP Children. Separate rate cells are presented within the appendices for the Medicaid and CHIP cohorts only because certain supplemental payments are not applicable to the CHIP subset of the children population. If this were not the case, then these rates would otherwise be presented as combined rate cells. From an operational perspective, the only difference between these populations is the funding stream and FMAP associated with the CHIP children (Title XXI) compared to the non-CHIP Medicaid children (Title XIX) and the fact that the supplemental GME payment is not applicable to the CHIP population.

Completion Factors

Optumas summarized the detailed SFY23 base data and compared it to the financial data shared by the MCOs. The SFY23 base data reflects encounters paid and submitted through January 31, 2024. Optumas developed MCO-specific Reporting/IBNR adjustments by comparing the raw non-subcapitated SFY23 encounter data to the MCO reported financials inclusive of MCO-reported IBNR estimates through December 31, 2023. The combined Reporting/IBNR adjustment was applied in aggregate for each MCO's SFY23 base data experience to reconcile these data sources and account for encounters not yet properly flowing through the MMIS system. As noted previously, the statewide, aggregate impact of the combined IBNR/Reporting adjustment was a 0.2% increase.

Optumas added the subcapitated costs reported in the MMIS encounter data, by cohort, to the Reporting/IBNR adjusted base data to ensure that all medical-related costs were considered in the development of the base data. The aggregate impact of this adjustment was a 0.3% increase to the statewide base data.

Additionally, other provider payments not inherent in the encounter data are detailed and identified within the MCO financials. Optumas worked collaboratively with the MCOs and Iowa Medicaid to interpret these payments and ensure they are reflected appropriately, by service and population, in the SFY23 base data. The adjustments for MCO provider incentives and settlement payments resulted in an aggregate 0.6% increase to the statewide base data.

The IA Health Link MCOs are permitted to pursue supplemental drug rebates for the CHIP Hawki population. The SFY23 encounter base data reflects pharmacy expenditures prior to accounting for the collection of drug rebates. Optumas used the SFY23 amounts reported within the MCO financial templates to reduce the CHIP Hawki population's pharmacy expenditures to reflect the final cost of pharmacy services, net of rebates. The adjustments for MCO pharmacy rebates resulted in an aggregate reduction of less than 0.01% to the statewide base data.

Finally, the IA Health Link MCOs provided claim recovery amounts in SFY23 related to coordination of benefits and subrogation within their reported financials. These costs are not reflected in the MMIS encounter base data, so Optumas applied the reduction in claim costs evenly across all populations and

categories of service, for each MCO. The adjustments for MCO subrogation and coordination of benefits resulted in an aggregate reduction of 0.1% to the statewide base data.

After applying these base data adjustments, the data sources consistently, accurately, and completely reflect the experience for the IA Health Link program in SFY23. The final adjusted base data is an appropriate starting point from which to project to the SFY25 contract period. Each of these adjustments are shown in greater detail at the rate cell level within Appendix I.B.

Errors in Data

Optumas validated the encounter data, benchmarked to MCO-reported financials, and concluded that no errors existed within the data.

Program Changes

This section outlines all program changes and adjustments made to the SFY23 base data within rate development, prior to trend, in order to appropriately reflect the policies in effect during the SFY25 contract period.

The impact of each of these program changes at the rate cell level is shown in Appendix I.B. A summary of all program changes and each component of the rate development is shown in Appendix II.B.

COVID-19 Meals

Effective March 13, 2020, Iowa Medicaid and the MCOs began authorizing and paying claims for service expansions of home delivered meals, homemaker services, and companion services for members who meet certain eligibility criteria for populations that are more susceptible to COVID-19 such as the HCBS Waiver members, members receiving Habilitation Services, and Medicaid members who are home bound. The COVID-19 service expansions were effective through the duration of the PHE proclamation, which ended on May 11, 2023. Of the services expanded, only the home delivered meals showed an increase in utilization within the SFY23 period relative to pre-COVID experience. As a result, Optumas identified the excess home delivered meals, by procedure code, to be removed from the SFY23 base data encounters, but no adjustment was applied for the homemaker and companion services.

COVID-19 Testing

Optumas has continued to monitor COVID-19 testing levels as part of the ongoing review of PHE-related utilization changes and observed a declining volume of COVID-19 testing expenditures in the SFY23 base period as well as the emerging SFY24 experience through December 2023. Following the end of the PHE, Optumas is not expecting a surge in COVID-19 testing utilization within the SFY25 contract period and has made an explicit downward adjustment to reflect the anticipated lower levels of COVID-19 testing that have been observed throughout the emerging SFY24 experience when compared to SFY23 base levels.

Copay Adjustment

During the COVID-19 PHE, the State suspended the collection of copays within the IA Health Link program. With the ending of the PHE, the State is expecting copays to resume for certain adult populations (non-pregnant Non-Expansion Adults and Wellness Plan Adults) and the CHIP – Hawki rate cell for non-emergent Emergency Room (ER) usage ($3 copay per visit for adults, $25 for Hawki).

Optumas identified the copay-applicable populations and services within the SFY23 base data and adjusted the MCO paid amounts to reflect the collection of copays that should occur within the contract period per state policy.

Removal of Pharmacy 90-Day Supply

During the COVID-19 PHE, the State allowed covered prescription and nonprescription medications to be dispensed for multiple month increments. Effective July 1, 2023, the policy reverted back to the pre-COVID policy, which allows a maximum 30-day supply for all pharmaceuticals, with the exception of contraceptives. Optumas reviewed the SFY23 claims data for multi-month scripts and adjusted pharmacy utilization to reflect the additional dispensing fees associated with the larger number of scripts expected in the contract period compared to the base period.

Dual Pharmacy Efficiency Adjustment

Optumas identified Medicare Part D pharmacy claims within the SFY23 base period for dual-eligible members where Medicaid was the primary payer instead of Medicare. These claims have been removed from the rates based on discussions with the MCOs.

Pharmacy Insulin Repricing

Starting in late 2023, manufacturers began reducing the price of insulin products. Consistent with the SFY24 rates, Optumas reviewed the SFY23 base data for the applicable National Drug Codes (NDCs) and repriced these claims using the latest Actual Acquisition Cost (AAC) pricing available.

Long-Term NF Service Coverage

Long-Term Nursing Facility (NF) stays are covered under the Iowa Health Link program. Iowa Medicaid released additional policy guidance clarifying the coverage of these services for certain populations in early 2023. Optumas reviewed SFY23 denied claims data through March 2023 provided by the State and MCOs and determined that a portion of these claims will be accepted under the new policy guidance. As a result, it is expected that the SFY25 contract period will have higher utilization of these services than what underlies the SFY23 base data experience, and the denied claims expenditures were used to estimate the rating impact.

FQHC and RHC Repricing

New FQHC and RHC PPS rates have gone into effect since the SFY23 base data time period. Consistent with prior cycles of rate development, the SFY23 base data encounters were repriced to reflect the most recent known payment rates for FQHCs and RHCs. A projected increase was also applied to account for the rate changes that will occur midway through the contract period on January 1, 2025.

Indian Health Service (IHS) Repricing

New IHS encounter rates have gone into effect since the SFY23 base data time period. Consistent with prior cycles of rate development, the SFY23 base data encounters were repriced to reflect the most recent known payment rates for IHS facilities. A projected increase was also applied to account for the rate changes that will occur midway through the contract period on January 1, 2025.

ICF/ID Repricing

Rates for ICF/IDs are updated annually. The most recent rate schedule at the time of rate development contains rates that are effective July 1, 2023. The SFY23 base data ICF/ID encounters were repriced to reflect the SFY24 rates. If the ICF/ID provider-specific rates are adjusted for SFY25, Optumas will revise

the repricing adjustment and submit a rate certification addendum reflecting the ICF/ID rates that will be paid during the contract period.

SRC Repricing

Rates for SRCs are periodically updated. Iowa Medicaid provided Optumas with the rates that are effective July 1, 2023. The SFY23 base data SRC encounters were repriced to reflect the most recent rates available. If the SRC provider-specific rates are revised for SFY25 Optumas will revise the pricing adjustment and submit a rate certification addendum reflecting the SRC rates that will be paid during the contract period.

NF Repricing

Rates for NFs are periodically updated. Effective July 1, 2023, HHS updated the base rate per diems and Quality Assurance Assessment Fee (QAAF) for Nursing Facility services as a result of legislative appropriations. Optumas repriced the NF experience underlying the SFY23 base data using the most recent NF provider specific rates available. If the NF provider-specific rates are adjusted for SFY25, Optumas will revise the NF repricing adjustment and submit a rate certification addendum reflecting the NF rates that will be paid during the contract period.

Hospice Repricing

Hospice rates are updated annually by CMS. Optumas used the most recent hospice rates, effective October 1, 2023, and repriced the hospice service utilization within the SFY23 base data to reflect the most recent reimbursement levels.

Behavioral Health Psychiatric Intensive Care (PIC) Medicaid Rate

Effective January 1, 2023, the State implemented a Medicaid rate for PIC hospital stays. Since this benefit is partially reflected in the SFY23 base data, Optumas made an adjustment to the July 2022 through December 2022 experience based on the actual January through June 2023 utilization of BH PIC services.

Multi-Systemic Therapy (MST) and Functional Family Therapy (FFT)

The state submitted a State Plan Amendment (SPA) to establish Medicaid coverage for MST and FFT during the SFY24 contract period. Optumas relied on initial projections from the State to develop the rating adjustment. It is assumed that 30 members will receive MST and 30 members will receive FFT services within the SFY25 contract period, costing on average $3,600 per year per person for FFT and $7,068 per year per person for MST.

SFY24 Mental Health (MH) Appropriation

Effective July 1, 2023, certain MH therapy services received a 54.91% rate increase as a result of the SFY24 legislative appropriations. Iowa Medicaid provided Optumas with the list of all applicable provider types, procedure codes, and modifiers that received the reimbursement increase. Optumas identified these providers and services within the SFY23 base data experience and applied the increase in reimbursement to these services.

SFY24 Psychiatric Medical Institutions for Children (PMIC) Appropriation

Effective July 1, 2023, PMIC services received a rate increase as a result of the SFY24 legislative appropriations. Iowa Medicaid provided Optumas with the list of all applicable provider types that received the new reimbursement rate of $464.95 per diem. Optumas identified these providers and

services within the SFY23 base data experience and applied the increase in reimbursement to these services.

SFY24 Substance Use Disorder (SUD) Appropriation

Effective July 1, 2023, SUD provider rates received a 96.47% rate increase as a result of the SFY24 legislative appropriations. Iowa Medicaid provided Optumas with the list of all applicable provider types, procedure codes, and modifiers that received the reimbursement increase. Optumas identified these providers and services within the SFY23 base data experience and applied the increase in reimbursement to these services.

SFY24 Community Mental Health Centers (CMHC) Appropriation

Effective July 1, 2023, CMHC services received an 18.23% rate increase as a result of the SFY24 legislative appropriations. Iowa Medicaid provided Optumas with the list of all applicable provider types, procedure codes, and modifiers that received the reimbursement increase. Optumas identified these providers and services within the SFY23 base data experience and applied the increase in reimbursement to these services.

Program Changes Deemed Immaterial to Benefit Expenses in the Rate Period

All policy changes effective between the SFY23 base data and SFY25 contract period were provided by Iowa Medicaid and analyzed by Optumas to determine the cost impact on the IA Health Link managed care program. The adjustments described above were determined to have a material impact to the MCOs and warranted a rating adjustment. No policy changes were determined to be immaterial and do not have an explicit adjustment within the SFY25 rate development.

Service and Payment Exclusions

The following services and payments have been excluded from the SFY23 MMIS encounter data underlying the base data development. Each of these exclusions is described within the base data development description in the preceding sections:

- GEMT state directed payments (included in a separate rating adjustment)
- Drugs in excess of $1. 5M since they are reimbursed outside of the capitation rates via invoicing
- COVID-19 Vaccine Administration (reimbursed outside of the capitation rates via invoicing)
- Value Added Services (not funded via capitation payments per CMS guidance)

3. Projected Benefit Costs and Trends

A. Rate Development Standards

i. Services Allowed

Final capitation rates are based only upon the services allowed in 42 CFR §§ 438.3(c)(1)(ii) and 438.3(e). No state-only funded services are included within the capitation rates as these services are not allowed to be included in the Medicaid rate certification submitted for CMS review and approval.

ii. Trend Assumptions

In accordance with 42 CFR §438.5(d), each projected benefit cost trend assumption is reasonable and developed in accordance with generally accepted actuarial principles and practices. Trend assumptions are developed primarily from actual experience of the Iowa Medicaid population and include consideration of other factors that may affect projected benefit cost trends through the rating period.

Trend factors were applied to estimate the change in utilization rate (frequency of services) and unit cost (pure price change, technology, acuity/intensity, and mix of services) of services over time. These trend factors were used to project the costs from the base period to the contract period. Trends were developed on a statewide, annualized basis and applied by major category of service (e.g., Inpatient, Professional) and broad population (e.g., TANF, Wellness Plan). Prospective trends were applied from the midpoint of the SFY23 base data (12/30/2022) to the midpoint of the SFY25 contract period (12/30/2024).

Prior to reviewing historical Iowa Medicaid experience, Optumas first normalized the SFY23 base data for programmatic and reimbursement changes described above, to ensure that the impact of these changes was not duplicated as both a rating adjustment and as trend. Once this was done, the historical IA Health Link encounter data was arrayed by rate cell, COS, and month of service, so that historical utilization/1,000, unit cost, and PMPMs could be reviewed. The data was arrayed so that 3-month moving averages (MMA), 6 MMA, and 12 MMA could be calculated. In general, a combination of these three metrics was used to determine prospective trend. However, there is not a pre-determined algorithm in place and trend assumptions vary based on nuances with a specific population or COS; given that prospective trend is a projection of future experience, it is necessary to make adjustments considering that historical trend experience may differ from what will materialize in the future. For example, certain populations and services experienced reductions in spend, but these negative trends were not necessarily projected into the contract period.

The annualized prospective utilization, unit cost, and PMPM trend assumptions by broad population and major category of service are included within Appendix II.C.

iii. In-Lieu-Of Services (ILOSs)

Iowa Medicaid policy has historically allowed for in-lieu-of services associated with beneficiaries residing in an institute for mental disease (IMD) up to fifteen days during a given month. Within the SFY25 contract period, additional in-lieu-of services may be provided in the IA Health Link program at the

discretion of the MCOs and Medicaid enrollees. No explicit adjustment has been included within the SFY25 rate development for these ILOSs since the MCOs and beneficiaries are not mandated to use these services and there is a requirement that each ILOS is a medically appropriate and cost-effective substitute for covered services or settings under the state plan.

iv. State Medicaid Director Letter on ILOSs

No explicit adjustment has been included within the SFY25 rate development for these ILOSs since these ILOS have not been provided historically and no utilization exists; additionally, MCOs and beneficiaries are not mandated to use these services and there is a requirement that each ILOS is a medically appropriate and cost-effective substitute for covered services or settings under the state plan.

Projected ILOS Cost Percentage

The projected ILOS cost percentage, excluding short term stays in an IMD, within the SFY25 capitation rates is 0%; no utilization experience currently exists for these services, since they have not been provided historically. Additionally, the MCOs and beneficiaries are not mandated to use these services and there is a requirement that each ILOS is a medically appropriate and cost-effective substitute for covered services or settings under the state plan. Due to the uncertainty surrounding future utilization, and the requirements noted above, the projected ILOS percentage of capitation rates is 0%.

Final ILOS Cost Percentage

Optumas will submit documentation of the final ILOS Cost Percentage for the SFY25 contract period as part of a separate actuarial report that must be submitted to CMS no later than two years after the completion of the contract period.

v. IMDs as an ILOS

Iowa Medicaid policy allows for experience specific to beneficiaries aged 21 to 64 residing in an IMD for less than fifteen days to be included within the IA Health Link capitation rates. These services were included within the IA Health Link contract during SFY23, which is the base data used for the SFY25 rates. Iowa Medicaid policy reimburses IMDs at the statewide average per diem of the comparable non-IMD facilities. As a result of this policy, no repricing of the IMD utilization has been conducted within rate development.

B. Appropriate Documentation

i. Final Projected Benefit Costs

The rate certification documents the final projected benefit costs by rate cell in Appendix I.B.

ii. Development of Projected Benefit Costs

Description of Data, Assumptions, and Methodologies

As described in the Base Data section and Trend Assumptions sections, Optumas relied on the MMIS encounter data provided by the State for the development of projected benefit cost trends and therefore projected costs of the IA Health Link SFY25 contract period. No material changes to the data, assumptions, and methodologies used outside of the program change adjustments previously described have occurred since the SFY24 rate certification.

The following adjustments were made after the application of trend to reflect the policies that will be in effect during the SFY25 contract period.

The impact of each of these post-trend program changes is shown in Appendix I.B for each rate cell. A summary of all applicable program changes and components of the rate development is shown in Appendix II.B.

CIOT Efficiency Adjustment

Optumas ran the SFY23 Health Link encounters through the Care Improvement Opportunity Tool (CIOT), an industry-standard episode of care grouper developed by Optumas in collaboration with Signify Health. The CIOT uses detailed clinical algorithms to group encounter data into episodes of care and compares the services provided, outcomes, and associated costs against clinically determined best practices to identify any inefficiencies in the form of Adverse Actionable Events (AAE).

The results of the episodes of care and associated AAE costs identified from the CIOT were evaluated within the SFY25 Health Link rate development as part of the cost containment initiatives in which Iowa Medicaid has been engaged.

The CIOT groups encounter data into episodes of care based on clinical definitions of look-back and look-forward time periods centered around typical trigger claims and services for each type of episode. Episodes include all clinically related services for a discrete condition or procedure for the entire continuum of care for a given period. Episodes were defined and refined with volunteer clinical experts assembled in Clinical Working Groups. Note, not all services provided during an episode window are considered relevant to the episode; therefore, not all encounters and services will be grouped into episodes of care. The CIOT tool identifies the following types of episodes:

- Chronic (17 conditions)
- Procedural (24 procedures)
- Other (Newborn and Pregnancy)

Optumas focused on the evaluation of Chronic episodes for this efficiency adjustment, since the MCOs should reasonably be able to impact costs within these episodes through proactively managing the care and behaviors for these members through interventions. The list of Chronic conditions evaluated is shown in *Table 5* below.

Table 5. CIOT Chronic Episodes

Chronic Episodes	
Arrhythmia / Heart Block / Conduction Disorder	Heart Failure
Asthma	Hypertension
Bipolar Disorder	Low Back Pain
Chronic Obstructive Pulmonary Disease	Osteoarthritis
Coronary Artery Disease	Schizophrenia
Crohn's Disease	Substance Use Disorder
Depression & Anxiety	Trauma & Stressors Disorders
Diabetes	Ulcerative Colitis
Gastro-Esophageal Reflux Disease	

Once episodes are identified, services are split into Typical and AAE. Typical service costs are routine and expected care for the episode, while AAEs are directly due to the condition/treatment and may potentially be avoided with more active care management, member behavior changes, and care coordination efforts from the MCOs. Optumas used the following considerations when identifying AAE costs that the MCOs may be able to reasonably impact with targeted efforts for chronic conditions. The following exclusions/limitations outline the process for translating the CIOT results into the managed care efficiency rating adjustment. Note that these specific limitations/criteria may be revised in future cycles, however we believe these to be reasonable for the first year of implementation. These are broken into episode, population, and service limitations:

1. Episode Limitations:
    a. Apply Episode Filters: Remove non-typical episodes from a clinical and cost perspective. Clinical filters include cases where a member has a condition that would make the episode clinically distinct and difficult to manage, such as the interaction with various cancers.
    b. Remove High-Cost Episodes: Remove the top 1% of episodes for each chronic episode type based on total costs.
2. Population Limitations:
    a. Duration Limit: Evaluate only members with at least six months of duration. The ability to impact costs associated with chronic conditions for members with shorter durations is limited compared to members with longer duration.
    b. Population Limit: Exclude long-term services and supports (LTSS) populations and non-risk adjusted populations. These populations have complicated conditions that may be more challenging for the MCOs to impact.
    c. Risk Score Limit: Exclude the top 10% of members with the highest concurrent risk scores in the SFY23 study period, using the University of California, San Diego (UCSD) Chronic Illness and Disability Payment System and Medicaid Rx model (CDPS+Rx) V7.1 tool for calculating risk scores. Members with higher risk scores may be more challenging for the MCOs to reduce AAE costs due to multiple comorbidities.
3. Service Limitations:
    a. Focus on Inpatient, Outpatient, and Emergency Room services (both physical health and behavioral health).

b. Reduce AAE for targeted COS by 50% to translate into potential savings. These have not been removed at 100%, as a mechanism to recognize that replacement costs for preventive services may be required to achieve savings for these AAE costs.

Postpartum Coverage Adjustment

During the SFY23 base period, the Pregnant Women rate cell experienced a significant accumulation of members who had more than the normally allowed two months of postpartum coverage. Now that the Maintenance of Eligibility (MOE) requirements are no longer in place, HHS will enforce the two months of postpartum coverage in the SFY25 contract period. An explicit adjustment has been made to reflect the two months of postpartum coverage, increasing the overall PMPM of the Pregnant Women rate cell.

This policy is expected to change on January 1, 2025, to cover twelve months of postpartum coverage with changes in the Federal Poverty Level (FPL) eligibility criteria. Once additional information is available regarding the updated policy, Optumas will revise the postpartum adjustment and submit a rate certification addendum reflecting the impact of this policy change.

Acuity Adjustment

Optumas developed an acuity adjustment to model the impact of the changing PMPM costs associated with the disenrollments that have occurred due to the end of the PHE continuous eligibility requirement (disenrollment freeze). Additional details related to this adjustment are provided in Section I.7 of this document.

Changes to Data, Assumptions, and Methodologies

Projected costs were developed in a manner consistent with the development of the SFY24 rates and generally accepted actuarial principles and practices.

Overpayments to Providers

Optumas is not aware of any specific overpayments to providers in the SFY23 base period that have not been accounted for within rate development.

iii. Projected Benefit Cost Trends

Data and Assumptions

Optumas used detailed IA Health Link encounter data, by major category of aid and major category of service, to develop projected benefit cost trends. The encounter data reviewed spanned from January 2022 through December 2023, with encounters paid and submitted through January 31, 2024. Trends were benchmarked and compared against the reported MCO financial data and emerging experience for the ongoing SFY24 contract period.

Methodology

Trend factors were applied to estimate the change in utilization rate (frequency of services) and unit cost (pure price change, technology, acuity/intensity, and mix) of services over time. These trend factors were used to project the costs from the base period to the future contract period. Trends were

developed on an annualized basis and applied by major population and major service category from the midpoint of the base period to the midpoint of the contract period.

Trend factors were developed for both utilization and unit cost using historical encounter data and MCO financial data. The historical encounter data was analyzed by major population and major COS. The data was arrayed such that 3 MMA, 6 MMA, and 12 MMA could be reviewed and evaluated. There is not a pre-determined algorithm used in determining the prospective annual trends. Each data summary is reviewed independently and prospective trend projections may vary depending on particular nuances within each COS or population. Trend was applied from the midpoint of the SFY23 base data (12/30/2022) to the midpoint of the SFY25 contract period (12/30/2024), for a total of 24 trend months.

Trend factors were developed consistent with generally accepted actuarial principles and practices and the methodology used is consistent with that of the annualized trends developed for the IA Health Link program's SFY19 through SFY24 rates.

Comparison to Historical Trends

The annual aggregate trend underlying the SFY25 IA Health Link rates is 2.6%, which is similar to the annual aggregate trend of 2.7% underlying the SFY24 capitation rates.

Outlier and Negative Trends

No negative or outlier trends were used for projection within the SFY25 rate development.

Components

The annualized prospective utilization and unit cost trend assumptions by major population and category of service are included within Appendix II.C.

Variations

Projected benefit cost trends were developed at the level of service and population categories shown within Appendix II.C. Trend assumptions were developed on a statewide basis for the entire IA Health Link program and do not vary by MCO. Similar rate cells were combined for trend development in order to increase credibility when developing trend projections and are shown within *Table 6* below.

Table 6. Trend Cohorts

Trend Cohort	Rate Cells Incorporated
Children	Children 0-59 Days M&F, Children 60-364 days M&F, Children 1-4 M&F, Children 5-14 M&F, Children 15-20F, Children 15-20M, CHIP - Children 0-59 Days M&F, CHIP - Children 60-364 days M&F, CHIP - Children 1-4 M&F, CHIP - Children 5-14 M&F, CHIP - Children 15-20F, CHIP - Children 15-20M, CHIP – Hawki
Disabled	ABD Non-Dual <21 M&F, ABD Non-Dual 21+ M&F, Residential Care Facility, Breast and Cervical Cancer
Dual	Dual Eligible 0-64 M&F, Dual Eligible 65+ M&F

Trend Cohort	Rate Cells Incorporated
Institutional	Custodial Care Nursing Facility <65, Custodial Care Nursing Facility 65+, Non-Dual Skilled Nursing Facility, ICF/ID, State Resource Center, PMIC
Maternity Case Rate	TANF Maternity Case Rate, Pregnant Women Maternity Case Rate
Pregnant Women	Pregnant Women
TANF Adult	Non-Expansion Adults 21-34 F, Non-Expansion Adults 21-34 M, Non-Expansion Adults 35-49 F, Non-Expansion Adults 35-49 M, Non-Expansion Adults 50+ M&F
Intellectual Disability (ID) Waiver	ID HCBS Waiver
Non-ID Waiver	Elderly HCBS Waiver, Dual HCBS Waivers: PD; H&D, Non-Dual HCBS Waivers: PD; H&D; AIDS, Brain Injury HCBS Waiver; Children's Mental Health HCBS Waiver
Wellness Plan (WP)	WP 19-24 F (Medically Exempt), WP 19-24 M (Medically Exempt), WP 25-34 F (Medically Exempt), WP 25-34 M (Medically Exempt), WP 35-49 F (Medically Exempt), WP 35-49 M (Medically Exempt), WP 50+ M&F (Medically Exempt), WP 19-24 F (Non-Medically Exempt), WP 19-24 M (Non-Medically Exempt), WP 25-34 F (Non-Medically Exempt), WP 25-34 M (Non-Medically Exempt), WP 35-49 F (Non-Medically Exempt), WP 35-49 M (Non-Medically Exempt), WP 50+ M&F (Non-Medically Exempt)

The aggregate annual PMPM trend used to project from the SFY23 base data to the SFY25 contract period is 2.6% using the SFY23 statewide base membership mix.

Other Material Adjustments

No other adjustments to projected benefit cost trends, either material or non-material, were made during the SFY25 rate development.

Other Non-Material Adjustments

No other adjustments to projected benefit cost trends, either material or non-material, were made during the SFY25 rate development.

iv. Mental Health Parity and Addiction Equity Act

Optumas is unaware of any material program changes that would require an adjustment for compliance with the Mental Health Parity and Addiction Equity Act as required by 42 CFR §438.3(c)(1)(ii). The projected benefit costs reflect payment amounts that are adequate to allow the MCOs to efficiently deliver covered services to Medicaid-eligible individuals in a manner compliant with contractual requirements.

v. In-Lieu-Of Services

Description of Each ILOS

No ILOSs outside of short term stays in an IMD existed within the SFY23 base data used for rate development. Appendix III contains the list of allowable ILOSs provided by Iowa Medicaid that are included within the SFY25 MCO contracts with service definitions, exclusions and limitations, as well as specific coding requirements for encounter data identification.

Projected ILOS Cost Percentage

The projected ILOS cost percentage in aggregate, excluding short term stays in an IMD, within the SFY25 capitation rates is 0% since there is no experience for these services within the SFY23 base data, nor emerging SFY24 data. Additionally, the MCOs and beneficiaries are not mandated to use these services and there is a requirement that each ILOS is a medically appropriate and cost-effective substitute for covered services or settings under the state plan. Each individual ILOS for the SFY25 contract period is projected to have a non-material impact on the SFY25 rates, with projected ILOS cost percentage of 0% since it is the first year of implementation and the level of utilization that the MCOs intend to provide these voluntary services to their beneficiaries is uncertain at the time of rate development.

Consideration of ILOSs in Projected Benefit Cost Development

There is no ILOS experience within the encounters underlying the SFY23 base data or experience reviewed for trend development. As such, no consideration for ILOSs has been made within the projected benefit cost development for the SFY25 rate since no explicit rating adjustment has been made.

IMD as an ILOS

Iowa Medicaid policy allows for experience specific to beneficiaries aged 21 to 64 residing in an IMD for less than fifteen days to be included within the IA Health Link capitation rates. These services were included within the IA Health Link contract during SFY23, which is the base data used for the SFY25 rates. Iowa Medicaid policy reimburses IMDs at the statewide average per diem of the comparable non-IMD facilities. As a result of this policy, no repricing of the IMD utilization has been conducted within rate development and the rates comply with the requirements of 42 CFR § 438.6(e).

vi. Retrospective Eligibility

Optumas has relied on the SFY23 IA Health Link experience as the base data used to develop the SFY25 capitation rates. Retroactive eligibility periods have historically been excluded from the IA Health Link program and continue to remain in FFS for the SFY25 contract period. Therefore, no adjustment has been made for retrospective eligibility in the development of the SFY25 capitation rates.

vii. Changes in Covered Benefits

Any changes to covered benefits in the IA Health Link program in SFY25 have been accounted for within the rate development and are described in detail above in Section I.2.B.iii.

viii. Impact of Changes

The impact of changes to covered benefits in the IA Health Link program in SFY25 are shown in Appendix I.B. Each change to covered benefits between the SFY23 base data and the SFY25 contract period includes an estimated impact to the projected benefit costs within the rate development summary in the appendices. A description of the data, assumptions, and methodologies used to develop each adjustment is included in Section I.2.B.iii. above.

No benefit changes were determined to be immaterial to the SFY25 rates. Each program change has an explicit adjustment described in Section I.2.B.iii.

4. Special Contract Provisions Related to Payment

A. Incentive Arrangements

There are no incentive arrangements included in the contract between the State and the MCOs in the IA Health Link program.

B. Withhold Arrangements

i. Rate Development Standards

Per the SFY25 IA Health Link contracts, 2.0% of premium is withheld by the State of Iowa and the MCOs can earn back the withhold to the extent that specific quality and performance measures are met as stated in the contract. These quality and performance measures are distinct from general operational requirements under the contract. The 2.0% withhold is not a component of the non-medical load since it is removed from the final capitation rate, net of the amounts itemized for the GME and GEMT additional payments. The withhold for SFY25 is consistent with the withhold percentages inherent in the SFY24 rates.

Per CMS guidance, contracts that provide for a withhold arrangement must ensure that the capitation payment minus any portion of the withhold that is not reasonably achievable is actuarially sound as determined by an actuary. The total amount of the withhold, achievable or not, must be reasonable and take into consideration the MCO's, prepaid inpatient health plan's (PIHP's) or prepaid ambulatory health plan's (PAHP's) financial operating needs accounting for the size and characteristics of the populations covered under the contract, as well as the MCO's, PIHP's or PAHP's capital reserves as measured by the risk-based capital level, months of claims reserve, or other appropriate measure of reserves.

The estimated percentage of the withhold that is expected to be earned back is between 60% and 100% based on a review of the earned withholds for the SFY20-SFY23 contract periods. To the extent that the IA Health Link MCOs do not earn back the withhold, the payment rate would still be reasonable and appropriate for the covered services and populations and the resulting rates would be actuarially sound and consistent with the CMS guidance mentioned above.

ii. Appropriate Documentation

Time Period of Withhold Arrangement

The time period of the withhold arrangement is consistent with the SFY25 rating period from July 1, 2024 through June 30, 2025.

Enrollees, Services, and Providers Covered

The 2.0% withhold applies to the aggregate capitation rate, net GME and GEMT, for all rate cells within the IA Health Link program for each MCO.

Purpose of the Withhold Arrangement

The purpose of the arrangement primarily relates to specified activities, targets, performance measures, and/or quality-based outcomes regarding timely claims processing and encounter data submissions, timeliness of prior authorizations, increasing network adequacy and service access for community-based behavioral health and LTSS services.

Description of the Total Percentage Withheld

The 2.0% withhold is based on total capitation rate revenue, net of the GME and GEMT additional payments, which is consistent with historical contract periods. Each MCO has the ability to earn back the withhold to the extent that specific quality and performance measures are met as stated in the contract. The capitation rates gross and net of the 2.0% withhold are shown in Appendix I.A.

Estimate of Percentage to be Returned

Based on emerging experience of the IA Health Link MCOs associated with the withhold earnings for prior rating periods and discussions with Iowa Medicaid, Optumas estimates that the MCOs will earn between 60% to 100% of the 2.0% withhold. This range aligns with expectations noted in prior rate cycles and continues to be substantiated by quarterly MCO financial reporting.

Reasonableness of Withhold Arrangement

Optumas' review of the total withhold percentage of 2.0% of capitation revenue is reasonable within the context of the IA Health Link capitation rate development.

Effect on capitation rate development

The withhold arrangements had no effect on the development of the capitation rates. The capitation payments, minus any portion of the withhold that is not reasonably achievable, are actuarially sound.

To the extent that the IA Health Link MCOs do not earn back the full withhold, the payment rate would still be reasonable and appropriate for the covered services and populations and the resulting rates would be actuarially sound.

C. Risk-Sharing Mechanisms

i. Rate Development Standards

This section provides supporting documentation and describes the risk-sharing arrangements between the State and the health plans. During the SFY25 contract period there will be a program-wide risk corridor due to the ongoing uncertainties associated with the ending of the COVID-19 PHE. Optumas worked with the State to develop a program-wide risk corridor based on the aggregate MLR percent experience across all populations and services for the MCOs. The profit and loss shares for the MCOs and the State for the different risk corridor bands are shown in *Table 7* below and are consistent with the risk corridor arrangement for the SFY24 contract period. To the extent a policy change, such as

modifications to the HCBS care coordination ratio and reporting requirements, results in an adjustment to the non-medical load component of the rates, the risk corridor will still remain +/- 3.0%, but the target will be updated based on the revised non-medical load amount built into the amended SFY25 rates.

Table 7. SFY25 Risk Corridor Arrangement

SFY25 Risk Corridor Bands		Profit/Loss Share	
Min. Threshold %	Max Threshold %	MCO	State
0.0%	87.7%	0%	100%
87.7%	90.7%*	100%	0%
90.7%*	93.7%	100%	0%
93.7%	93.7%+	0%	100%

**The target MLR of 90.7% is based on the weighted average of total non-medical load amounts built into the SFY25 rates using the SFY23 enrollment distribution. The actual target used for the final reconciliation will vary slightly based on the actual population distribution for the MCO during the SFY25 contract period. To the extent the target MLR varies from 90.7% using the actual MCO enrollment mix during the contract period, the risk corridor bands will still be +/- 3.0% from the revised target MLR.*

In accordance with 42 CFR §438.6(b), the risk-sharing mechanism outlined above in the rate certification is consistent with that documented in the MCO contracts and was determined prior to the start of the rating period. The risk corridor was developed in accordance with §438.4, the rate development standards in §438.5, and generally accepted actuarial principles and practices. Iowa Medicaid and Optumas acknowledge that risk-sharing mechanisms may not be added or modified after the start of the rating period.

The risk corridor reconciliation will be applied prior to the calculation of the minimum MLR and any recoupments necessary between the MCO and State will be incorporated as an adjustment to revenue prior to the minimum MLR calculation.

The SFY25 IA Health Link capitation rates have been developed as full risk rates. The only other risk-sharing arrangements between the MCOs and the State for the SFY25 contract period are associated with the state directed payments described in Section I.4.D below. Specifically, for the SFY25 contract period, the University of Iowa Hospitals and Clinics (UIHC) Physician Average Commercial Rate (ACR) and both UIHC and non-UIHC Hospital ACR directed payments are structured as separate payment term arrangements that are reimbursed outside of the capitation rates. These arrangements will have a retrospective reconciliation performed after the end of the SFY25 contract period based on actual utilization incurred by eligible providers through the directed payment arrangement. Further details on these specific arrangements are outlined in Section I.4.D. No other risk-sharing arrangements apply within the IA Health Link program outside of those previously mentioned.

ii. Appropriate Documentation

Description of Risk-Sharing Arrangements

The program-wide risk corridor settlement is the calculated gain or loss determined when comparing the actual MLR developed from the SFY25 experience to the risk sharing corridor percentages in *Table 7* above. The actual MLR is calculated as the total adjusted medical expenditures divided by the total capitation rate for all populations. The total capitation rate excludes any taxes and fees built into the rates, as well as amounts related to GME or any directed payments implemented as a separate payment term for which the MCO is not at risk (e.g., UIHC Physician ACR, and both UIHC and non-UIHC Hospital ACR payments).

Adjusted medical expenditures shall be determined by the State and Optumas based on encounter data and plan financial data submitted by each MCO. Adjusted medical expenditures only include services covered by the IA Health Link program and will exclude all expenditures associated with carve-out services such as high-cost drugs with costs above $1.5M per dose or treatment and claims that were invoiced to Iowa Medicaid as part of the COVID-19 vaccine administration. The MCOs may provide services to enrollees that are in addition to those covered under the State Plan (i.e., value-add services); however, per the MCO contracts, the cost of these services will not be included within the risk corridor calculation for the SFY25 contract period and were not included within the development of the SFY25 capitation rates. Additionally, administrative expenditures included in the pharmacy claims will be removed from the expenditures for purposes of the risk corridor calculation as applicable. The final adjusted medical expenditures will not include quality improvement expenses, case management expenses, or other administrative expenses. Adjusted medical expenditures will not include amounts related to GME or any directed payments implemented as a separate payment term for which the MCO is not at risk (e.g., UIHC Physician ACR payment as well as the UIHC and non-UIHC Hospital ACR payments). Items such as fraud, waste, and abuse, will not be considered in the numerator of the MLR risk corridor calculation.

The implementation of the risk corridor and MLR requirement did not impact the development of the actuarially sound capitation rates or influence any of the adjustments made within rate development. The risk-sharing mechanism has been developed in accordance with generally accepted actuarial principles and practices and is consistent with pricing assumptions used in capitation rate development, as shown in *Table 7.* No remittance/payment will be made if the MCOs actual MLR experience is within +/- 3.0% of the pricing assumptions used in capitation rate development.

MLR Arrangement

The program-wide risk corridor settlement is the calculated gain or loss determined when comparing the actual MLR developed from the emerging experience to the risk sharing corridor percentages in *Table 7*. Any MLR experience outside of the +/- 3.0% risk corridor bands will result in a transfer of funds between the MCO and Iowa Medicaid. The target MLR of 90.7% noted in *Table 7* is based on the weighted average of total non-medical load amounts built into the SFY25 rates using the SFY23 enrollment distribution. The actual target used for the final reconciliation may vary slightly based on the actual population distribution for the MCO during the SFY25 contract period. To the extent the target MLR varies from 90.7% using the actual MCO enrollment mix during the contract period, the risk corridor bands will still be +/- 3.0% from the revised target MLR.

In addition to the risk corridor arrangement, the State requires all health plans to maintain a minimum MLR of 88%. If an MCO's MLR is less than 88%, after adjusting revenue for the risk corridor reconciliation, the health plans must refund the State the difference. Plan submitted MMIS encounters and reported financials will be reconciled to the assumed experience included in the SFY25 rates to evaluate any MLR payments necessary after the risk corridor reconciliation. The methodology for the minimum MLR calculation differs from the MLR-based risk corridor, as a result of allowable differences including but not limited to the inclusion of Health Care Quality Improvement, Health Information Technology, and External Quality Review expenditures in the numerator for the minimum MLR calculation that are not allowable in the risk corridor calculation.

Reinsurance

The contracts between HHS and the MCOs require that the MCOs comply with reinsurance requirements of 191 Iowa Administrative Code 40.17 and shall file with the Agency all contracts of reinsurance or a summary of the plan of self-insurance. The contractor shall provide to the Agency the risk analysis, assumptions, cost estimates, and rationale supporting its proposed reinsurance arrangement.

D. State Directed Payments

i. Rate Development Standards

There are four state directed payment initiatives associated with the IA Health Link managed care program for the SFY25 contract period that are in accordance with 42 CFR §438.6(c). Three of these arrangements (UIHC Physician ACR payments, as well as the separate UIHC and non-UIHC Hospital ACR payments) will be implemented as separate payment term structures that are reimbursed outside of the SFY25 capitation rates. Optumas has received and reviewed each state directed payment preprint and confirms that each state directed payment documented below is consistent with the applicable preprints. At this time, the preprints for each of the ACR provider payment arrangements have been approved by CMS for the SFY25 contract period, while the GEMT directed payment is expected to be submitted on June 21, 2024.

Iowa Medicaid and Optumas understand that in accordance with 42 CFR §438.6(c)(2), all state directed payments, except for minimum fee schedules using Medicaid State plan approved rates as defined in 42 CFR §438.6(a), must receive written prior approval from CMS and that the review of the rate certification and related contract actions that incorporate these state directed payments cannot be finalized until all necessary written prior approvals are obtained. The state directed payments included in the rate certification are consistent with the information in the preprints that have been, or will be, submitted to CMS for review.

All contract arrangements that direct the IA Health Link MCOs' expenditures were developed in accordance with 42 CFR §438.4, the standards specified in §438.5, and generally accepted actuarial principles and practices.

There are no requirements regarding the reimbursement rates the plans must pay to any providers unless specified in this certification as a directed payment or authorized under applicable law,

regulation, or waiver. No additional directed payments exist within the IA Health Link managed care program for SFY25 outside of the four arrangements described below. Each of the payment arrangements is accounted for in the rate development in a manner consistent with the preprint that has been submitted, or will be submitted, in the case of the GEMT payment, to CMS for review. The sections below describe how each state directed payment arrangement under §438.6(c) is either incorporated into the base capitation rates as an adjustment as defined in §438.5(f) or addressed through a separate payment term.

UIHC Physician ACR Payments

Description of Arrangement

The UIHC Physician ACR state directed payment was originally approved by CMS for the SFY19 IA Health Link contract period and the arrangement has been renewed annually through the SFY24 contract period. The UIHC Physician ACR directed payment is a uniform percentage increase in reimbursement for physician and professional services at qualifying Iowa State-Owned or Operated Professional Services Practices. The State plans to continue the arrangement in SFY25 and has submitted and received approval of the necessary preprint for the July 1, 2024 through June 30, 2025 contract period.

The additional payment made to these qualifying physicians under the uniform percent increase provides support for contracting and maintaining access for Medicaid beneficiaries to the applicable physicians. Under this arrangement, in accordance with 42 CFR §438.6(c)(2)(ii)(B), a supplemental payment for covered physician services will be made for the services provided by a faculty or staff member of a qualifying Iowa State-Owned or Operated Professional Services Practice to reflect the uniform percent increase in reimbursement. Currently, only physicians affiliated with the University of Iowa meet this definition. Base reimbursement for these services is Iowa Medicaid reimbursement and the supplemental (directed) payment brings the final reimbursement to an Average Commercial Rate level.

Consistent with the SFY24 contract period, Iowa Medicaid received approval for the arrangement to be operated as a separate payment term and reimbursed outside of the capitation rates. Thus, there will be a retrospective reconciliation of payments after the contract period ends and the UIHC Physician ACR PMPMs reflected within Appendix I.C reflect initial estimates for this separate payment term arrangement. Once actual utilization for SFY25 is available, Optumas and Iowa Medicaid will calculate revised PMPMs using the actual claims incurred for each rate cell under the arrangement and actual membership for the contract period. Any differences between the original Physician ACR estimate (calculated as the rate cell specific PMPMs x SFY25 membership) and actual claims incurred under the arrangement will be paid out as a lump sum payment/recoupment from Iowa Medicaid to the MCOs. After the rating period is complete and the State makes any necessary reconciliation payment/recoupment, Optumas will submit a rate certification addendum outlining the distribution methodology and revised PMPMs that reflect the final payments made under this arrangement for SFY25.

Rating Adjustment

The methodology used to calculate the initial estimate for this arrangement is described below and is consistent with the information submitted by the State in the §438.6(c) preprint approved by CMS for the SFY25 rating period.

Optumas received a list of University of Iowa providers from the State, which was used to identify claims and services attributed to providers who are eligible to receive the enhanced ACR fee schedule reimbursement. The SFY23 data reflects the Medicaid reimbursement for all claims under this arrangement and the basis for the supplemental payment is the difference between the customary Medicaid rate and the average commercial rate for specific physician service procedure codes. Optumas relied on the total amount of the directed payment estimated by HHS within the directed payment preprint and allocated the directed payment expenditures based on the distribution of applicable services across rate cells within the SFY23 base data to calculate estimated PMPMs shown within Appendix I.C. The MCOs are responsible for paying the calculated differential payments to qualifying practices based on actual utilization within the contract period.

This supplemental PMPM, which does not contain any applied non-medical load, is the estimated amount of the impact of implementing the uniform percent increase to commercial reimbursement for physician and professional services at qualifying Iowa State-Owned or Operated Professional Services Practices.

The estimated PMPMs by rate cell for the UIHC Physician ACR directed payment are shown in Appendix I.C. The estimate is based on historical utilization of services by qualifying physicians and practitioners. The actuaries are certifying the amount of the initially estimated separate payment term within this certification. Once actual experience for SFY25 is available, the retrospective reconciliation will be performed and the initial PMPM estimates, shown in Appendix I.C, will be revised to reflect the actual experience incurred for each rate cell with an addendum submitted to CMS outlining the final payments made under the arrangement.

UIHC Hospital ACR Payments

Description of Arrangement

Effective July 1, 2021, the UIHC Hospital ACR payment was a new state directed payment for inpatient and outpatient hospital services at qualifying Iowa State-Owned teaching hospitals with more than 500 beds and eight or more distinct residency specialty or subspecialty programs recognized by the American College of Graduate Medical Education. The uniform percent increase directed payment is structured in accordance with 42 CFR §438.6(c) and will continue within the SFY25 contract period.

The additional payment made to these qualifying hospitals under the uniform percent increase provides support for contracting to maintain/expand access to services essential for Medicaid beneficiaries. Under this arrangement, in accordance with 42 CFR §438.6(c)(2)(ii)(B), a supplemental payment for qualifying Inpatient and Outpatient hospital services will be made to reflect the reimbursement of the uniform percent increase. Currently, only the University of Iowa Hospitals and Clinics meets the eligibility criteria for the directed payment arrangement. Base reimbursement for these services is Iowa

Medicaid reimbursement and the supplemental (directed) payment brings the final reimbursement to an average commercial rate level.

For the SFY25 contract period the Hospital ACR directed payment will be reimbursed outside of the Health Link capitation rates via a separate payment term structure. Optumas has developed an estimate for the separate payment term arrangement consistent with the approved preprint. The methodology used to estimate the payments associated with the hospital directed payment is similar to the physician arrangement described previously. The basis for the supplemental payment is the difference between the provider's negotiated Medicaid managed care reimbursement and the average commercial rate (uniform percent increase) calculated using an ACR payment-to-charge ratio for inpatient and outpatient (both acute and behavioral health) hospital services. The MCOs are responsible for paying the calculated differential payments to qualifying providers based on actual utilization on a per claim basis within the contract period.

Once actual utilization for SFY25 is available, Optumas and Iowa Medicaid will calculate revised PMPMs using the actual claims incurred for each rate cell under the arrangement and actual membership for the contract period. Any differences between the original UIHC Hospital ACR estimate (calculated as the rate cell specific PMPMs x SFY25 membership) and actual claims incurred under the arrangement will be paid out as a lump sum payment/recoupment from Iowa Medicaid to the MCOs. After the rating period is complete and the State makes any necessary reconciliation payment/recoupment, Optumas will submit a rate certification addendum outlining the distribution methodology and revised PMPMs that reflect the final payments made under this arrangement for SFY25.

Rating Adjustment

The methodology used to calculate the initial estimate for this arrangement is described below and is consistent with the information submitted by the State in the §438.6(c) preprint approved by CMS for the SFY25 rating period.

Optumas received a list of hospitals eligible for this directed payment from the State, which was used to identify claims and inpatient and outpatient services in the SFY23 data that will be eligible to receive the enhanced ACR reimbursement during the contract period. The State also provided the most recent average ratio of payment to charges for the top five commercial payors split between inpatient and outpatient services and the preprint that was submitted to CMS for approval containing the total estimate for the directed payment arrangement. Optumas relied on the total amount of the directed payment estimated by HHS within the required preprint and allocated the estimated directed payments based on the distribution of UIHC inpatient and outpatient services across rate cells within the SFY23 base data to develop the estimated PMPMs shown in Appendix I.C. The differential between the commercial reimbursement calculated and the customary Medicaid reimbursement represents the supplemental directed payment that will be paid on a per claim basis for the eligible inpatient and outpatient services. These supplemental PMPMs are an estimate of the directed payment arrangement but are not included within the capitation rates paid monthly to the MCOs. Once actual utilization for the contract period is available, Optumas will submit an addendum with the final PMPM costs associated with the hospital directed payment by rate cell to CMS.

The estimated PMPMs for each rate cell associated with the UIHC Hospital ACR Payment are shown in Appendix I.C. The estimated payments were developed based on historical utilization of Inpatient and

Outpatient services by qualifying hospitals. The actuaries are certifying the amount of the initially estimated separate payment term within this certification. Once actual experience for SFY25 is available, the retrospective reconciliation will be performed and the initial PMPM estimates, shown in Appendix I.C, will be revised to reflect the actual experience incurred for each rate cell with an addendum submitted to CMS outlining the final payments made under the arrangement.

Non-UIHC Hospital ACR Payments

Description of Arrangement

Effective July 1, 2023, the Non-UIHC Hospital ACR payment was a new state directed payment for all non-state owned or operated hospitals eligible to receive inpatient and/or outpatient payments consistent with the State Plan Attachments 4.19A and 4.19B. All hospitals except for the UIHC hospitals are eligible to participate in this directed payment program. The uniform percent increase directed payment is structured in accordance with 42 CFR §438.6(c) for the SFY25 contract period.

The additional payment made to these qualifying hospitals under the uniform percent increase provides additional funding for rate increases to hospitals that will help ensure continued access to hospital care and improve quality of care received by Medicaid enrollees. Under this arrangement, in accordance with 42 CFR §438.6(c)(2)(ii)(B), a supplemental payment for qualifying Inpatient and Outpatient hospital services will be made to reflect the reimbursement of the uniform percent increase. Base reimbursement for these services is Iowa Medicaid reimbursement and the supplemental (directed) payment brings the final reimbursement to 90% of the average commercial rate level.

For the SFY25 contract period the Non-UIHC Hospital ACR directed payment will be reimbursed outside of the Health Link capitation rates via a separate payment term structure. Optumas has developed an estimate for the separate payment term arrangement consistent with the approved preprint. The methodology used to estimate the payments associated with the hospital directed payment is similar to the UIHC Physician and Hospital ACR arrangements described previously. The basis for the supplemental payment is the difference between the provider's negotiated Medicaid managed care reimbursement and 90% of the average commercial rate (uniform percent increase). The MCOs are responsible for paying the calculated differential payments to qualifying providers based on actual utilization on a per claim basis within the contract period.

Once actual utilization for SFY25 is available, Optumas and Iowa Medicaid will calculate revised PMPMs using the actual claims incurred for each rate cell under the arrangement and actual membership for the contract period. Optumas will submit a rate certification addendum outlining the distribution methodology and revised PMPMs that reflect the final payments made under this arrangement for SFY25.

Rating Adjustment

The methodology used to calculate the initial estimate for this arrangement is described below and is consistent with the information submitted by the State in the §438.6(c) preprint approved by CMS for the SFY25 rating period.

Optumas identified all non-UIHC hospital inpatient and outpatient services within the SFY23 base data that will be eligible to receive the enhanced ACR reimbursement during the contract period. The State provided the preprint that was submitted to CMS for approval containing the total estimate for the non-UIHC Hospital ACR directed payment arrangement. Optumas relied on the total amount of the directed payment estimated by HHS within the required preprint and allocated the estimated directed payments based on the distribution of non-UIHC inpatient and outpatient services across rate cells within the SFY23 base data to develop the estimated PMPMs shown in Appendix I.C. The differential between the commercial reimbursement calculated and the customary Medicaid reimbursement represents the supplemental directed payment that will be paid on a per claim basis for the eligible inpatient and outpatient services. These supplemental PMPMs are an estimate of the directed payment arrangement but are not included within the capitation rates paid monthly to the MCOs. Once actual utilization for the contract period is available, Optumas will submit an addendum with the final PMPM costs associated with the hospital directed payment by rate cell to CMS.

The estimated PMPMs for each rate cell associated with the Non-UIHC Hospital ACR Payment are shown in Appendix I.C. The estimated payments were developed based on historical utilization of Inpatient and Outpatient services for qualifying hospitals. The actuaries are certifying the amount of the initially estimated separate payment term within this certification. Once actual experience for SFY25 is available, a retrospective reconciliation will be performed and the initial PMPM estimates, shown in Appendix I.C, will be revised to reflect the actual experience incurred for each rate cell with an addendum submitted to CMS outlining the final payments made under the arrangement.

GEMT Payment Program

Description of Arrangement

Effective July 1, 2019, the State implemented the GEMT Payment Program in accordance with 42 CFR §438.6(c) and incorporated the approved supplemental GEMT payment program into the Iowa State Plan via SPA transmittal #19-0002. The GEMT Payment Program is made to qualifying Emergency Medical Service (EMS) providers within Iowa for Emergency Medical Transportation services. Iowa Medicaid provided Optumas with the list of applicable providers and procedure codes that will be receiving the prospective provider-specific payment rates during the SFY25 contract period. The provider-specific rates reflect an approved dollar amount increase and are based on CMS-approved GEMT cost reports submitted by the EMS providers. The EMS additional payments will provide support for contracting and maintain access for Medicaid beneficiaries to receive GEMT services. Under this arrangement, in accordance with 42 CFR §438.6(c)(2)(ii)(B), the supplemental payment for covered emergency transportation services will be billed under procedure code A0999 for the services provided by an approved EMS provider participating in the GEMT Payment Program. The A0999 procedure codes associated with the GEMT directed payment arrangement were excluded from the SFY23 base data underlying rate development to avoid duplication with this supplemental payment calculation. The GEMT state directed payment was incorporated into the rate certification in the base capitation rates as a rate adjustment consistent with the anticipated preprint that is expected to be submitted to CMS on June 21, 2024. The final version of the preprint was not available at the time of certification submission but the arrangement built into the rates is consistent with the approved SPA GEMT supplemental payment program.

The payment arrangement for the SFY25 contract period will be based on actual emergency transportation service utilization within the contract period and is structured such that the MCOs pay both the customary Medicaid rate and the supplemental provider-specific prospective rate when adjudicating claims. The provider-specific prospective payment rate, billed under procedure code A0999, represents the additional uncompensated actual costs necessary to perform EMS transports based on submitted cost reports. Base reimbursement for the eligible emergency transportation services is Iowa Medicaid reimbursement. The supplemental payment (state directed uniform dollar increase) reflects the provider-specific Medicaid uncompensated care cost per transport to fully reimburse eligible EMS providers for the applicable services.

Rating Adjustment

The providers receiving the supplemental payment associated with the GEMT program are eligible EMS providers who will continue submitting CMS-approved cost reports that will be used to calculate their supplemental prospective payment in future fiscal years. The State provided Optumas the list of eligible EMS providers who will be participating in the program for the SFY25 contract period and accompanying provider-specific rates, which were used to calculate the supplemental PMPM amount noted below.

The supplemental payment for GEMT is calculated based on emergency transport service utilization for qualifying EMS providers within the SFY23 base data, at the rate cell level, projected to the SFY25 contract period. The GEMT PMPMs by rate cell are shown in Appendix I.B and the amounts are included within the base capitation rates.

ii. Appropriate Documentation

To comply with 42 CFR §§ 438.7(b)(6) and 438.6(c), the rate certification and supporting documentation includes a description of each state directed payment utilized by the state within the IA Health Link manage managed care program. *Table 8* below contains a brief summary of each applicable state directed payment for the SFY25 contract period.

Table 8. IA Health Link State Directed Payments

State Directed Payment Control Name	Type of Payment	Brief Description	Rate Adjustment or Separate Payment Term?
UIHC Physician ACR Payment Control Name: IA_Fee_AMC_Renewal_20240701-20250630	Uniform Percentage Increase	Reimbursement increase to Average Commercial Rate for applicable services. Reference preceding section for more information.	Separate Payment Term
UIHC Hospital ACR Payment Control Name: IA_Fee_IPH.OPH_Renewal_20240701-20250630	Uniform Percentage Increase	Reimbursement increase to Average Commercial Rate for applicable services. Reference preceding section for more information.	Separate Payment Term

State Directed Payment Control Name	Type of Payment	Brief Description	Rate Adjustment or Separate Payment Term?
Non-UIHC Hospital ACR Payment Control Name: IA_Fee_IPH.OPH1_Renewal_20240701-20250630	Uniform Percentage Increase	Reimbursement increase to 90% of the Average Commercial Rate for applicable services. Reference preceding section for more information.	Separate Payment Term
GEMT Payment Control Name: Information not yet available	Uniform Dollar Increase	Provider specific supplemental payments set based on CMS-approved cost reports. Reference preceding section for more information.	Rate Adjustment

In compliance with 42 CFR §§ 438.7(b)(6) and 438.6(d), further details are included in *Table 9* below for the GEMT state directed payment that is included within the base capitation rates.

Table 9. Directed Payments Included Within the Capitations Rates

State Directed Payment Control Name	Rate Cells Affected	Impact	Description of the Adjustment	Confirmation that the Rates are Consistent with the Preprint
GEMT Payment Control Name: Information not yet available	All Except Maternity Case Rate Payments	Please see column BP of Appendix I.B labelled "GEMT"	Please see the GEMT Rating Adjustment in Section I.D.i above	Optumas has not yet received the final directed payment preprint. The rating adjustment is accounted for in a manner consistent with the approved SPA and preprint that will be submitted to CMS for review.

Further details are included in *Table 10* below for the ACR directed payments that will be operated as separate payment terms with reimbursement outside of the IA Health Link capitation rates for the SFY25 contract period.

Table 10. Directed Payments Operated as Separate Payment Terms

State Directed Payment Control Names	Aggregate Amount of Payment*	Certifying Statement	Magnitude on a PMPM Basis	Confirmation of Consistency	Confirmation of End of Rating Period Documentation
UIHC Physician ACR Payment Control Name: IA_Fee_AMC_ Renewal_20240701-20250630	Please see column E of Appendix I.C. labelled "Total UIHC Physician ACR Estimate"	The actuaries are certifying the estimated PMPMs shown within Appendix I.C.	Please see column D of Appendix I.C. labelled "UIHC Physician ACR PMPM"	This state directed payment is accounted for in a manner consistent with the approved preprint.	After the rating period is complete, documentation that incorporates the total amount of the state directed payment into each rate cell will be submitted consistent with the distribution methodology included in the preprint.
UIHC Hospital ACR Payment Control Name: IA_Fee_IPH.OPH_ Renewal_20240701-20250630	Please see column G of Appendix I.C. labelled "Total UIHC Hospital ACR Estimate"	The actuaries are certifying the estimated PMPMs shown within Appendix I.C.	Please see column F of Appendix I.C. labelled "UIHC Hospital ACR PMPM"	This state directed payment is accounted for in a manner consistent with the approved preprint.	After the rating period is complete, documentation that incorporates the total amount of the state directed payment into each rate cell will be submitted consistent with the distribution methodology included in the preprint.
Non-UIHC Hospital ACR Payment Control Name: IA_Fee_IPH.OPH1_ Renewal_20240701-20250630	Please see column I of Appendix I.C. labelled "Total Non-UIHC Hospital ACR Estimate"	The actuaries are certifying the estimated PMPMs shown within Appendix I.C.	Please see column H of Appendix I.C. labelled "Non-UIHC Hospital ACR PMPM"	This state directed payment is accounted for in a manner consistent with the approved preprint.	After the rating period is complete, documentation that incorporates the total amount of the state directed payment into each rate cell will be submitted consistent with the distribution methodology included in the preprint.

** The estimated aggregate amount of the directed payment is shown based on the SFY23 base data membership multiplied by the estimated SFY25 PMPMs and will vary within the SFY25 contract period based on actual service utilization experience and actual membership.*

There are no additional directed payments in the program that are not addressed in this certification documentation including minimum fee schedules using Medicaid State plan approved rates as defined in 42 CFR §438.6(a).

There are no requirements regarding the reimbursement rates the managed care plans must pay to any providers unless specifically specified above as a state directed payment or authorized under applicable law, regulation, or waiver.

E. Pass-Through Payments

GME payments are incorporated within the SFY25 capitation rates and reflect payments to hospitals for graduate medical education programs. However, the GME payment is outside of the standard definition of pass-through payments per 42 CFR 438.6(a); therefore, there are no pass-through payments in the IA Health Link SFY25 contract period.

Although the GME payment is outside the standard definition of pass-through payments per 42 CFR 438.6(a), Optumas has included the description and amount of the GME payment in this section of the certification letter. The GME payments are made to teaching hospitals for the purpose of funding GME within the state. These payments are received by teaching hospitals with an accredited medical education program and are funded with direct State appropriations to the Medicaid agency. These amounts are paid to the teaching hospitals by the MCOs but are not included in the contracted rates between the plans and the hospitals.

The amount of GME payments included in the SFY25 capitation rates is $5.04 PMPM for applicable rate cells and represents a slight increase on a PMPM basis to the amounts included within the SFY24 capitation rates due the decreased membership as a result of the PHE unwinding disenrollments. The PMPMs by rate cell are shown in Appendix I.B.

5. Projected Non-Benefit Costs

A. Rate Development Standards

i. Required Components

In accordance with 42 CFR §438.5(e), the development of the non-benefit component of the rate includes reasonable, appropriate, and attainable expenses related to MCO administration, taxes, licensing and regulatory fees, contribution to reserves, risk margin, and cost of capital. In addition, the non-benefit component includes other operational costs associated with the provision of services under the contract, including those administrative costs for compliance with the mental health parity standards in 42 CFR §438.3, subpart K.

ii. PMPM and Percentage of Capitation Rates

Non-benefit costs were developed as a percentage of the capitation rates, net additional payments (UIHC Hospital and Physician ACR payments, Non-UIHC Hospital ACR payments, GEMT, and GME) described in Section I.4.D and Section I.4.E above.

B. Appropriate Documentation

i. Development

Description of Data

Non-benefit costs were developed using financial data reported by each MCO for SFY23 through SFY24 Q2 (July 2022 – December 2023) along with a review of non-benefit costs in Medicaid programs from states with similar covered populations and services. In developing the non-benefit cost assumptions, consideration was given to economies of scale associated with the new MCO starting July 1, 2023 and the disenrollments as part of the ending of the PHE associated with COVID-19, as well as fixed and variable costs, resulting in variation between final non-benefit cost projections across populations. The level of non-benefit costs necessary varies between populations to effectively manage care. Non-benefit costs are shown by rate cell in Appendix I.B.

Material Changes/Adjustments

There were no material changes or adjustments in the development of the non-medical load for the SFY25 capitation rates from that of the SFY20 through SFY24 capitation rates. Optumas reviewed MCO financial templates summarizing costs quarterly for SFY23 through SFY24 Q2. In developing non-benefit cost assumptions, consideration was given to economies of scale associated with the new MCO starting July 1, 2023 and the disenrollments as part of the ending of the PHE associated with COVID-19, as well as fixed and variable costs. These considerations have resulted in a slight increase to the administrative load on a PMPM and percentage of premium basis compared to SFY24. The statewide non-medical load varies by rate cell and is applied consistently to all MCOs for all rate cells. The SFY25 load is approximately 9.3% in aggregate, using the SFY23 base membership mix.

Note that an update to the non-benefit cost percent is expected to occur within a rate amendment as a result of HHS finalizing a policy revision to the HCBS care coordination and reporting requirements under the MCO contracts. No explicit adjustments have been made to the non-medical load assumption for this policy change at this time.

ii. Cost Categories

The non-medical cost load includes administrative costs and an allocation for profit, risk, and contingency which is 1.75% of premium for all rate cells. This amount is consistent with that of the SFY20 through SFY24 capitation rates.

Effective January 1, 2024, a 0.975% premium tax was implemented for each of the Medicaid MCOs on gross premium revenues, including directed payments. The premium tax is applied to the rates net of the 2.0% withhold as a percent of total premium, and any earned withhold will be adjusted for the 0.975% premium tax after evaluation of the withhold amount earned by each MCO. The premium tax adjustment is separate from the non-medical load assumption built into the rates.

Effective January 1, 2025, the premium tax is expected to reduce to 0.95%. To the extent that this or any other changes to the premium tax amount materialize, Optumas will submit a revised midyear rate addendum, for the effective date of the change, to account for the change in premium tax.

iii. Historical Non-Benefit Cost Data

As described in the sections above, the historical non-benefit cost data provided by the IA Health Link MCOs was relied upon when developing the non-medical load assumptions within the SFY25 capitation rates. The MCOs provided financial information for the SFY23 base period and emerging SFY24 non-benefit experience. Optumas reviewed all quarterly data for consistency but relied primarily on the SFY23 time period for developing the non-medical load assumptions for rate development since this aligns with the base data period. Optumas and Iowa Medicaid will continue to monitor the non-benefit cost data provided by the IA Health Link MCOs in future rate development cycles.

6. Risk Adjustment

A. Rate Development Standards

i. Risk Adjustment

Optumas accounted for the relative risk in the health status of enrollees in each MCO through a combination of health-based risk scores based on UCSD's CDPS+Rx tool and cost-based relativity factors for certain LTSS populations for the SFY25 rate development. The methodology is similar to that of the SFY24 rate development.

Optumas developed and applied risk scores or relativity factors for most populations within the IA Health Link program. The populations that were adjusted within the SFY25 rates are consistent with the populations that were adjusted within the SFY24 rate development. The general approach for the risk score calculations and cost-based relativity factor development is largely consistent with prior cycles of rate development, with updated study periods and snapshot periods. A description of the methodology is included in the following section for completeness.

ii. Methodology

Consistent with 42 CFR §438.5(g), Optumas worked with Iowa Medicaid to select a prospective risk adjustment and relativity adjustment methodology that uses generally accepted models. The adjustment factors are applied in a budget neutral manner, consistent with generally accepted actuarial principles and practices.

B. Appropriate Documentation

i. Risk Adjustment

In accordance with 42 CFR §438.7(b)(5)(i), the rate certification describes all prospective risk adjustment methodologies below.

Data

Optumas relied on January 1, 2023 – December 31, 2023 (CY23) enrollment and encounter data as the study period for capturing the relevant diagnoses and pharmacy information used to calculate member risk scores and develop the relativity factors at the rate cell level. Iowa Medicaid provided Optumas with member-level MCO capitations through March 2024 that were used to attribute the members within the CY23 base data period to Wellpoint, Iowa Total Care, and Molina. The capitation data contains detailed member-level demographic information for members enrolled within the three MCOs each month. The final MCO risk/relativity adjustment factors used in SFY25 rate development reflect an aggregation of actual experience for CY23. Optumas relied on the March 2024 snapshot month to assign members and their associated risk scores to each MCO, and the December 2023 snapshot month to assign members and their associated cost-based relativity factors to each MCO, for purposes of prospective risk adjustment in the SFY25 capitation rate development. December 2023 was used for the

relativity factors due to the inherent lag in capitation payments that has been historically observed for the LTSS populations within the IA Health Link program.

Model

Optumas developed and applied risk scores or relativity factors for most populations within the IA Health Link program. The populations that were adjusted within the SFY25 rates are consistent with the populations that were adjusted within the SFY24 rate development. The general approach for the risk score calculations and cost-based relativity factor development is largely consistent with prior cycles of rate development, with updated study periods and snapshot periods. Note, within SFY24 cost-based relativity factors were blended with risk scores for the populations that have generally been just risk adjusted. Based on better stabilization of enrollment within the Health Link program between the three MCOs compared to the early months of SFY24, Optumas has applied 100% risk adjustment to such populations this cycle.

Optumas applied health-status based risk scores to most non-LTSS populations. Risk scores were developed using UCSD's CDPS+Rx V7.1 tool, with national prospective weights and a March 2024 enrollment snapshot. The modeling was developed with a 6-month eligibility duration requirement, such that members had to have at least 6 months of enrollment within the CY23 study period to be scored. Unscored members received the regional average disease weight of scored members for each rate cell, along with their member-specific demographic weight.

The specific rate cells attributed to each MCO that have fewer than 300 unique members were adjusted for credibility by using the classical credibility formula:

$$\sqrt{\frac{Member\ Count}{300}} = \text{weight given to the MCO-specific risk score, with a maximum of } 100\%$$

The complement percentage was given to the statewide average risk score for that rate cell for each snapshot month. The result is a credibility adjusted risk score that mitigates bias due to rate cell sample size.

The following standard Medicaid populations are risk adjusted using CDPS+Rx risk scores:

- Children (over the age of one)
- Non-Expansion Adults
- Wellness Plan Adults
- ABD Non-Duals

Populations that are adjusted via a relativity factor, rather than via CDPS+Rx risk adjustment, are Dual populations and cohorts that have significant LTSS utilization and expenditures. CDPS+Rx risk adjustment does not adequately capture the differences in risk profiles for these populations since typical Medicaid risk adjustment tools rely mainly on acute care services and the majority of costs for these populations are either covered by Medicare or are LTSS. Instead, relativity factors were developed by comparing the total PMPM of each rate cell, by MCO, to the statewide PMPM for the rate cell in the CY23 experience period. The December 2023 capitation data was used to identify member months and costs associated with members enrolled with Wellpoint, Iowa Total Care, and Molina since it is the most recent month of complete enrollment experience for each MCO at the time of rate development. By

comparing the relative PMPM, by rate cell for each MCO, an initial MCO relativity factor was developed for each rate cell. Note, there are some members who were present throughout CY23, but were not present in December 2023 per the capitation data. These members were excluded from the initial relativity factor calculation.

Optumas reviewed the prevalence of members with $100k+ claims in the CY23 data, by rate cell, for members assigned to each MCO. This review was conducted to ensure that the use of a cost-based relativity factor does not skew results as a result of one or two high outlier claims. After reviewing, Optumas determined there was no compelling reason to make an explicit adjustment for members with high-cost claims as part of the relativity factor development.

Optumas reviewed the average CY23 enrollment duration for members assigned to Wellpoint, Iowa Total Care, and Molina to understand the differences and consider whether significant differences in duration played a role in the relativity factor development. Upon review, Optumas observed that no explicit adjustment to the relativity factor development was necessary for durational differences.

The CY23 experience reflects encounters submitted through April 2024. Optumas reviewed monthly relativity factors between the MCOs, to determine whether any differences in the timing of claims payments and encounter submissions may be impacting the original CY23 relativity factors described above. Optumas reviewed rolling averages of the monthly relativity factors and monthly PMPMs for each MCO and determined that no smoothing adjustment was necessary.

The December 2023 snapshot period is within the SFY24 contract period which contains several unique enrollment circumstances that have caused significant membership changes between MCOs: allocation of members to a third MCO entering the market within SFY24, shifting of members between MCOs during the open enrollment period, and Iowa Medicaid's decision to temporarily assign 100% of new auto-enrollees to Molina HealthCare effective December 4, 2023. Iowa Medicaid provided Optumas with member choice reports for new members enrolling with each MCO through February 2024. A review of emerging capitation data through April 2024 and the member choice reports shows that Molina continues to get a higher volume of new enrollees, effectively increasing their share of the total program's membership, consistent with the expectations of the ongoing auto-assignment policy. As a result, Optumas has blended the actual cost-based relativity factors for the relativity-adjusted populations with the statewide average of 1.0. The blended factors use a 90% weighting for the cost-based relativity factors, with 10% weight for the statewide 1.0, to reflect the fact that Molina is expected to continue to receive a higher proportion of new individuals who will presumably look like the statewide average for these populations as their membership share continues to increase throughout the SFY25 contract period.

Relativity factors were used for the following Dual and LTSS populations:

- Residential Care Facility
- Dual Eligible Members
- Custodial Care Nursing Facility
- HCBS Waiver Members
- ICF/ID
- PMIC

The remaining populations that are neither risk adjusted, nor relativity-factor adjusted, receive statewide rates. These rate cells have insufficient membership levels for risk adjustment to be credibly applied or are populations that are typically comprised of entirely new members in subsequent years:

- Newborns
- Pregnant Women
- Maternity Case Rates
- Breast and Cervical Cancer
- Non-Dual Skilled Nursing Facility
- State Resource Center

A table detailing the risk adjustment model used for each rate cell, along with the resulting factors, is shown in Appendix II.D.

Methodology

The risk adjustment and relativity factors were applied to the statewide rates in a budget neutral manner consistent with historical rate developments. The risk and relativity adjustment methodologies follow the use of generally accepted actuarial principles and practices that surround standard risk adjustment. Appendix II.E demonstrates the budget neutrality of the risk adjustments made to split the statewide rates into MCO-specific risk adjusted rates for each applicable rate cell. Consistent with the statewide rate development, same-demographic Children and CHIP rate cells were combined for credibility in developing the risk adjustment factors.

Magnitude

A proxy SFY23 membership mix for each MCO was developed using the distribution of members between Wellpoint, Iowa Total Care, and Molina for each rate cell within the March 2024 capitation file. This proxy SFY23 MCO enrollment is used when aggregating the totals within Appendix II.E. and Appendix II.F. The magnitude of the risk/relativity adjustment is an increase of 2.2% for Wellpoint, an increase of 1.6% for Iowa Total Care, and a decrease of 6.3% for Molina, based on each MCO's respective SFY23 proxy membership. The impact by rate cell and in total for each MCO is shown in Appendix II.F.

Assessment of Predictive Value

Optumas reviewed the raw risk scores by rate cell developed for the SFY25 IA Health Link rates to the raw risk scores within the SFY24 rate development and compared the MCO-specific normalized risk scores to the relativity factors used within the SFY24 rate development. In general, the normalized risk scores for most populations were directionally consistent with the SFY24 rate development. As more recent experience becomes available for the IA Health Link program, Optumas and Iowa Medicaid will continue to monitor and review the correlation between the relativity factors and relative costs by MCO and rate cell to determine if there are further shifts in relative acuity of the population between MCOs.

Concerns

At this time, Optumas does not have concerns with the predictive value of the risk and relativity adjustment methodology used within SFY25 for predicting the relative risk differences between MCOs.

ii. Retrospective Risk Adjustment

No retrospective risk adjustment has been made in the development of the SFY25 rates.

iii. Changes to Risk Adjustment Model and Budget Neutrality

The risk adjustment model remained largely consistent between the SFY24 and SFY25 rate development cycles. Within the SFY24 rate development, Optumas used UCSD's CDPS+Rx V7.0 health-status based risk adjustment tool, which has been updated to V7.1 for the SFY25 rates. The SFY24 contract period contained several unique enrollment circumstances that have caused significant membership changes between MCOs: allocation of members to a third MCO entering the market within SFY24, shifting of members between MCOs during the open enrollment period, and Iowa Medicaid's decision to temporarily assign 100% of new auto-enrollees to Molina HealthCare effective December 4, 2023. As a result, in SFY24 rate development, cost-based relativity factors were blended with risk scores for the populations that have generally been just risk adjusted using a 40%/60% blend of normalized risk scores and cost-based relativity factors, respectively. Based on the capitations data provided by the State there is better stabilization of enrollment within the Health Link program between the three MCOs compared to the early months of SFY24. Therefore, Optumas has applied 100% risk adjustment to such populations for the SFY25 rate development.

Dual eligible and certain LTSS populations continue to be risk adjusted using cost-based relativity factors by plan compared to statewide PMPMs. Iowa Medicaid provided Optumas with member choice reports for new members enrolling with each MCO through February 2024. A review of emerging capitation data through April 2024 and the member choice reports shows that Molina continues to get a higher volume of new enrollees, effectively increasing their share of the total program's membership, consistent with the expectations of the ongoing auto-assignment policy. As a result, Optumas has blended the actual cost-based relativity factors for the relativity-adjusted populations with the statewide average of 1.0. The blended factors use a 90% weighting for the cost-based relativity factors, with 10% weight for the statewide 1.0, to reflect the fact that Molina is expected to continue to receive a higher proportion of new individuals who will presumably look like the statewide average for these Dual and LTSS populations as their membership share continues to increase throughout the SFY25 contract period.

All risk/relativity adjustments are applied in a budget neutral fashion in accordance with 42 CFR §438.5(g). Appendix II.E demonstrates the budget neutrality of the risk adjustments made to split the statewide rates into MCO-specific rates for each applicable rate cell.

7. Acuity Adjustment

A. Rate Development Standards

i. Risk Adjustment

An adjustment applied to the total payments across all managed care plans to account for significant uncertainty about the health status or risk of a population is considered an acuity adjustment, which is a permissible adjustment under 42 CFR § 438.5(f) (81 FR 27595).

Optumas has applied a prospective acuity adjustment within the SFY25 IA Health Link rates to account for the significant member disenrollments and subsequent changing population as a result of the COVID-19 PHE unwinding.

B. Appropriate Documentation

i. Acuity Adjustment Description

Reason for Health Status Uncertainty

In response to the COVID-19 pandemic, HHS implemented a disenrollment freeze for all IA Medicaid populations, with few exceptions in line with federal guidance, effective March 1, 2020, through the duration of the PHE proclamation. The freeze on disenrollment resulted in members who would normally lose eligibility for IA Medicaid remaining enrolled with an IA Health Link MCO in the SFY23 base data period, through the end of the PHE and until redeterminations are completed. The acuity adjustment applied to the SFY25 rates accounts for an expected increase in per capita costs due to the expiration of the PHE. Beginning in April 2023, HHS began the process to disenroll members due to the expiration of the MOE requirement. This disenrollment process continued throughout the rest of SFY23 and throughout SFY24 and therefore is not fully inherent in the SFY23 base data being used to develop the SFY25 rates.

Model

Optumas reviewed enrollment data over time to determine members in the base data that have been disenrolled due to the end of the COVID-19 PHE disenrollment freeze and are expected to no longer be in the program during the SFY25 contract period. Optumas observed that the members who have been disenrolled because of the PHE Unwind (“PHE Leavers”) have lower costs in the base data relative to members who are anticipated to remain in the program. The “PHE Leavers” were identified based on a snapshot period of January 2022 through April 2024. Members who were in the program as of January 2022, before any disenrollments began, and are no longer in the April 2024 capitation data are considered “PHE Leavers”. Note, individuals who joined the program after January 2022 but have since left are not considered “PHE Leavers” since these individuals were not enrolled in the program for a prolonged period of time and are more indicative of typical churn populations. Additionally, any individuals who left the program prior to April 2023 are not considered “PHE Leavers” since they left for allowable reasons during the PHE.

Removing these lower-cost members who have been disenrolled from the program as a result of the PHE unwinding results in an increase to the base PMPMs. The acuity adjustment is an upward adjustment in aggregate, with the magnitude of the adjustment varying by rate cell. The same rate cells that were adjusted within the SFY24 rates have been adjusted within the SFY25 acuity adjustment.

Data Used

Optumas relied on enrollment data from January 2022 through April 2024 to classify members as "PHE Leavers" within the acuity adjustment. The SFY23 encounter base data and corresponding enrollment was reaggregated based on the member classification to develop the acuity adjustment impact.

Potential Interactions

When evaluating trend, Optumas removed the experience for members classified as "PHE Leavers" for the CY22 through CY23 data to estimate secular trends without the interaction of the increasing acuity as members gradually disenrolled between April 2023 through December 2023.

Frequency of Calculation

Based on conversations with Iowa Medicaid, the IA Health Link enrollment is expected to stabilize at the end of the SFY24 contract period. There is not expected to be further significant member disenrollment going forward. As such, the prospective acuity adjustment that has been applied to the current SFY25 rates is not expected to be recalculated, since the data used reflected disenrollments through April 2024.

Adjustment to Rates

The acuity adjustment results in an aggregate increase to the rates with the magnitude of the adjustment varying by rate cell based on the volume of disenrollments and PMPM cost-differentials of "PHE Leavers" and population remaining enrolled within the program.

Documentation

The acuity adjustment applied within the SFY25 IA Health Link rates has been developed in accordance with generally accepted actuarial principles and practices.

Section II. Medicaid Managed Care Rates with Long-Term Services and Supports

1. Managed Long-Term Services and Supports

A. Applicability of Section I for MLTSS

Optumas confirms the development of the SFY25 rates for the managed long-term services and supports (MLTSS) populations is consistent with the guidance and documentation noted above in Section I of the required standards for rate development and CMS' expectations for appropriate documentation.

The IA Health Link program covers individuals receiving LTSS services across several rate cells. Beneficiaries in these rate cells include elderly and disabled individuals, including all home and community-based waiver enrollees. A significant portion of services provided to these members are LTSS benefits including nursing facility, home care, and HCBS waiver services. The IA Health Link program includes individuals receiving the following services:

- Intermediate care facility or nursing home care
- ICF/ID facilities
- State resource centers
- Hospice
- Psychiatric mental institutions for children
- HCBS Waiver Services, including:
    - Physical Disability Waiver
    - Health and Disability Waiver
    - AIDS Waiver
    - Brain Injury Waiver
    - Elderly Waiver
    - Children's Mental Health Waiver
    - Intellectually Disability Waiver

The SFY25 rates were developed for all services incurred by LTSS members, with the exception of dental services. These services are carved out of the IA Health Link capitation rates since dental services are covered by a separate Iowa Medicaid dental managed care program.

B. Rate Development Standards

i. Rate Blending

Optumas developed the LTSS capitation rates by blending the individual rate cells for each LTSS rating group. The rating groups are consistent with those used within the SFY19 through SFY24 rate developments and include the following:

- LTSS Elderly
- LTSS Physically Disabled
- LTSS Intellectually Disabled
- LTSS Children's Mental Health.

The capitation data provides the actual mix of Institutional and Waiver members that each MCO had enrolled within their organization as of December 2023. Note that while the December 2023 enrollment was used to inform the MCO-specific mix assumptions, the statewide target reflects the overall SFY23 LTSS mix underlying the SFY23 base data.

C. Appropriate Documentation

i. Payment Structures

Capitation payments for LTSS benefits are paid as a single capitation rate to the MCOs for each LTSS rating group outlined above. The total MCO payments vary based on actual MCO enrollment. As noted above, Optumas has relied on the December 2023 enrollment to inform the MCO-specific mix assumptions, but the aggregate statewide SFY23 mix remains constant for each LTSS blended rate group.

The individual LTSS rate cells are blended using the rating groups mentioned in Section II.1.B. above. A summary of the rate blending methodology is shown in Appendix II.G. The development of the individual LTSS rate cells including the base data, assumptions, and general methodologies for program changes and overall rate setting are consistent with the traditional Medicaid populations and are described within Section I.

The capitation payments made to the MCOs are reflective of the rates (net withhold) shown within Appendix I.A based on the members enrolled within the Health Link MCO for each month of the contract period.

The rates within Appendix I.A are the rates paid to the MCOs. Appendix I.A rates reflect the blended LTSS rates shown within Appendix II.G, with the additional directed payments included for each rate cell. A summary of the additional payments that are added after the LTSS rate blending (GME and GEMT) are shown in Appendix I.B. The GME and GEMT additional payments vary by individual rate cell based on service utilization differences and because providers are not eligible to receive enhanced payments for all populations (e.g., dual eligible members). The UIHC Physician as well as UIHC and Non-UIHC Hospital ACR directed payments are operationalized via separate payment term arrangements that are reimbursed outside of the capitation rates, but initial PMPM estimates for these arrangements for the LTSS rate cells have been included in Appendix I.C.

ii. Non-Benefit Costs

The non-medical load for the LTSS population was developed in a manner consistent with the approach for all IA Health Link populations. Further details can be found in Section I.5 of this certification letter.

iii. Sources

The LTSS capitation rates were developed using SFY23 encounter data as the basis for the rates with program change adjustments, trend, and non-medical load assumptions developed in a manner consistent with the approach for all IA Health Link rate cells described throughout Section I.

Section III. New Adult Group Capitation Rates

1. Data

A. New Adult Group Data

The same data sources used to set the SFY25 rates for the traditional Medicaid populations were used to develop rates for the new adult group. IA Health Link encounter data for the WP new adult group, as described in Section I.2, was primarily used to develop SFY25 rates.

B. Previous Rating Periods

i. New Data

Optumas used IA Health Link experience from SFY23 as the basis for SFY25 rate development since this was the most recent complete year of data for the IA Health Link program. Additionally, encounter data through December 2023 and enrollment data through April 2024 was used to inform trend projections, risk-adjustment, and the PHE unwind acuity adjustment.

ii. Monitor Costs

Iowa Medicaid and Optumas will continue to review emerging experience for the WP population and will consider the necessity of rebasing or any additional adjustments in future rate developments should emerging experience vary materially from cost projections.

iii. Actual Experience Compared with Expectations

Optumas believes that the use of SFY23 IA Health Link experience as the basis for rate development should better align payment to risk for the SFY25 contract period as compared with the pre-IA Health Link data used in the early years of IA Health Link rate development.

iv. Adjustment for Differences

Optumas has used SFY23 encounter data as the base data for the SFY25 rates, which incorporates the most recent WP population's actual experience under the IA Health Link program. Therefore, no adjustment has been made for any differences between actual experience compared with expectations. It is expected that the use of SFY23 IA Health Link experience, along with the acuity-based adjustment noted in Section III.2.A.iii below, will better align payment to risk for the SFY25 contract period as compared to prior rate development cycles.

2. Projected Benefit Costs

A. New Adult Group Required Documentation

i. New Adult Groups Covered in Previous Rating Periods

Optumas worked with Iowa Medicaid to utilize SFY23 IA Health Link encounter data as the base for the SFY25 capitation rates. Emerging data through April 2024 was used to help inform a variety of rating adjustments described within Section I of this certification.

No adjustments were made for the following items as a result of using actual IA Health Link program experience:

- Pent-up demand
- Adverse selection
- Demographic changes
- Differences in provider reimbursement rates, as these differences do not exist between the WP and non-WP populations

All benefit plan changes have been documented in Section I of this certification letter. No additional benefit plan changes specific to the WP population have been made.

ii. New Adult Groups Not Covered in Previous Rating Periods

Not applicable. The IA Health Link program has covered the new adult group populations since the program's inception in April 2016.

iii. Key Assumptions

Acuity Adjustments

Optumas made an acuity adjustment related to the ending of the disenrollment freeze as part of the COVID-19 PHE unwind for the WP population in the same manner as the other populations that were adjusted for acuity changes. The methodology for this adjustment is outlined in Section I.7.

Pent-up Demand

The WP population has had several years of experience within the Iowa Medicaid program at the time of the SFY23 base data period, so no adjustment for pent-up demand was deemed necessary.

Adverse Selection

The WP population has had multiple years of experience with the Iowa Medicaid program, and no significant changes in the population are expected, so no adjustment for adverse selection was deemed necessary.

Demographics

The WP population has had multiple years of experience with the Iowa Medicaid program, and no significant changes in the population are expected, so no adjustment for demographic changes was deemed necessary.

Provider Reimbursement and Networks

Any reimbursement or network adjustments made as part of the program change adjustments were applied to all populations and are described in Section I. Any variations in the assumptions used to develop the projected benefit costs for IA Health Link covered populations were based on valid rate development standards and not based on the rate of federal financial participation associated with the covered populations.

Other Adjustments

No other adjustments were made to the WP projected benefit costs outside of those previously described in Section I.

B. Other Material Changes or Adjustments to Projected Benefit Costs

No other adjustments were made to the WP projected benefit costs outside of those previously described in Section I.

3. Projected Non-Benefit Costs

A. Required Components

i. Changes in Methodology

Projected non-benefit costs for the WP populations were developed using the same data, methodology, and assumptions as the traditional Medicaid populations, described in Section I.5. No other methodology changes have been made to the projected non-benefit costs between the SFY24 and SFY25 IA Health Link rate developments for the WP population.

ii. Changes in Assumptions

Projected non-benefit costs for the WP population were developed using the same data, methodology, and assumptions as the traditional Medicaid populations, described in Section I.5. No other changes in assumptions for the following items have been made to the projected non-benefit costs between the SFY24 and SFY25 IA Health Link rate developments outside of what has already been described in Section I.5:

- Administrative costs
- Care coordination and care management
- Provision for operating or profit margin
- Taxes, fees, and assessments
- Other material non-benefit costs

B. Key Assumptions

Optumas used the same assumptions in developing the statewide non-benefit costs for the WP and traditional Medicaid populations. The development of non-benefit costs for all populations is described in Section I.5 and non-benefit costs are shown by rate cell and MCO in Appendix I.B.

4. Final Certified Rates

A. Required Components

i. Comparison to Previous Rates

Consistent with CMS' request under 42 CFR §438.7(d), Appendix II.A contains a comparison of the final certified SFY25 statewide rates to the final rates from the previous SFY24 rate certification. This appendix contains the comparison for all rate cells, including the Wellness Plan populations.

ii. Other Material Changes

No other material changes outside of what has previously been described in this document were made to the rate development for either the standard Medicaid populations or the new adult Wellness Plan populations.

5. Risk Mitigation Strategies

A. Description of Strategy

As discussed in Section I.4, the SFY25 IA Health Link capitation rates have been developed as full risk rates. There is a program-wide risk corridor in place for the SFY25 contract period, but there are no risk mitigation strategies that are specific to only the Wellness Plan population. Both the risk corridor and minimum MLR requirement apply to the overall IA Health Link program, across all populations.

B. Comparison to Previous Period

i. Changes in Strategy

There have been no changes in risk mitigation strategy for IA Health Link in SFY25 compared to SFY24 that are specific to the Wellness Plan population.

ii. Rationale for Change

There has been no change from the SFY24 rates in use of a risk corridor specific to the WP population.

iii. Experience and Results

No risk mitigation strategy has been in place specific to the WP population. Therefore, there is no relevant information available for prior rate cycles.

Actuarial Certification Letter

We, Barry Jordan, Director/Consulting Actuary at Optumas and Member of the American Academy of Actuaries (MAAA) and a Fellow of the Society of Actuaries (FSA), and Stephanie Taylor, Senior Manager/Consulting Actuary at Optumas and Member of the American Academy of Actuaries (MAAA) and an Associate of the Society of Actuaries (ASA), are certifying the calculation of the capitation rates described in this certification letter. Appendix I contains the Rate Development Summaries and final capitation rates for all cohorts for each MCO. We meet the qualification standards established by the American Academy of Actuaries and have followed the practice standards established from time to time by the Actuarial Standards Board.

The capitation rates provided with this certification are considered actuarially sound for purposes of 42 CFR § 438.4, according to the following criteria:

- The capitation rates have been developed in accordance with generally accepted actuarial principles and practices,
- The capitation rates are appropriate for the populations to be covered, and the services to be furnished under the contract; and
- The capitation rates meet the requirements of 42 CFR § 438.4.

The actuarially sound rates that are associated with this certification are effective July 1, 2024 through June 30, 2025 for the IA Health Link Managed Care program.

The actuarially sound capitation rates are based on a projection of future events. Actual experience may vary from the experience assumed within the rate projection. The capitation rates offered may not be appropriate for any specific Managed Care Organization (MCO). An individual MCO should review the rates in relation to the benefits that it is obligated to provide to the covered population and to its specific business model. The MCO should evaluate the rates in the context of its own experience, expenses, capital, surplus, and profit requirements prior to agreeing to contract with Iowa Medicaid. As a result of this evaluation, the MCO may require rates above or below the actuarially sound rates associated with this certification.

Please feel free to contact Barry at 480.588.2492 or email Stephanie at stephanie.taylor@optumas.com for any additional information.

Sincerely,

Barry Jordan, FSA, MAAA
Director/Consulting Actuary, CBIZ Optumas

Stephanie Taylor, ASA, MAAA
Sr. Manager/Consulting Actuary, CBIZ Optumas

Appendices

Detailed tables containing data summaries, analyses, and assumptions used within the SFY25 rate development are shown within the accompanying Microsoft Excel appendices:

- IA Health Link SFY25 Rate Certification Appendix I 2024.06.20.xlsx
- IA Health Link SFY25 Rate Certification Appendix II 2024.06.20.xlsx

The list of allowable ILOSs provided by Iowa Medicaid that are included within the SFY25 MCO contracts is contained within the following PDF that accompanies this document:

- IA Health Link SFY25 Rate Certification Appendix III 2024.06.20.xlsx